PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC     STREET ADDRESS, CITY, STATE, ZIP CODE   1081 THIRD AVENUE, SW, SUITE # 5		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC   (X4] ID PREFIX IS SUMMARY STATEMENT OF DEFICIENCIES 108 THIRD AVENUE, SW, SUITE #5 CARMEL, IN 46032  (X4] ID PREFIX IS CARMEL, IN 46032  (X4] ID PREFIX IS CARMEL, IN 46032  (X5) OR ONLY IN A 16032  (X6) OR ONL					_			
ALL AGES HOME HEALTH CARE INC  O(A) ID  SUMMARY STATEMENT OF DEFICIENCIES (PRETIX REGULATORY OR LSC IDENTIFYING INFORMATION)  G 000  INITIAL COMMENTS  This was a Federal Complaint Survey. The survey was extended survey on 10/09/15.  Complaint #IN00164290 - Substantiated with deficiencies  Survey dates: October 8, 9, and 13, 2015  Facility Number: 013568  Medicaid Provider ID: Not Available  Census: 6  Home visits: 1  Active Clinical records reviewed: 6  Closed records reviewed: 3  All Ages Home Health Care, Inc. is precluded from providing its own training and competency evaluation program for a period of 2 years beginning October 13, 2015, to October 13, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.14  Organization, Services, and Ad4-30 Skilled Nursing Services, 484.36 Home Health Aide Services, Medical Supervisor, 484.36 Home Health Aide Services, 484.36 Home Health			15K131	B. WING _			10/	13/2015
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Comprehensive Assessment of Patients.  484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT  Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected	G 114	from providing its own evaluation program for beginning October 13 for being found out of Conditions of Particip Organization, Services 484.18 Acceptance of Medical Supervision, Services, 484.36 Hord 484.48 Clinical Record Comprehensive Asses 484.10(e)(1(i-iii) PATI PAYMENT  Before the care is initiating patient, orally and (i) The extent to which	n training and competency or a period of 2 years 3, 2015, to October 13, 2017, compliance with the ation 42 CFR 484.14 es, and Administration, f Patients, Plan of Care, 484.30 Skilled Nursing ne Health Aide Services, eds, and 484.55 ssment of Patients. ENT LIABILITY FOR integration of the competency	G ·	114			
from Medicare, Medicaid, or any other Federally  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE	LABORATORY					TITLE		(YE) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARI			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	I	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 114	(ii) The charges for covered by Medicar (iii) The charges that pay.	gram known to the HHA; services that will not be	G 11	4		
	Based on record re inform the patient, of charges for services that the individual marecords reviewed, p	eview the agency failed to by and in writing, the set that may not be covered and hay have to pay for in 9 of 9 to tentially affecting all 6 tervices within the agency.				
	07/20/15. The Adm dated 07/20/15, was	umber 1, SOC (start of care) ission Service Agreement is reviewed and failed to es that may occur for services insurance benefit.				
	Admission Service was reviewed and f	umber 2, SOC 07/29/15. The Agreement dated 04/28/15, ailed to evidence the charges services not covered by the				
	11/13/14. A letter to indicated " As it v admission process, you at no charge ur transitioned to a full offering you and / o weekday decision p	3, SOC (start of care) to the patient dated 06/08/15, was explained during the we agreed to provide care for till our temporary license was licensure We are r your family a five (5) eriod starting from the date er to make your decision on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		15K131	B. WING		C 10/13/2015
NAME OF PROVIDER  ALL AGES HOME		1		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013
	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
this properiod contact a. Notice "private b. indicate the foll"  c. 11/13/r part of that mapassed licensu.  d. include service 4. Clir Admiss was rethat mainsurar 5. Clir Admiss was rethat mainsurar 6. Clir Admiss and contact the mainsurar 6. Clir Admiss contact the mainsurar 6. Clir	The Home H dated 11/13/1 e services to be a letter to the ed "Your servicowing payor so the Italian provision and the provision and occur for sed their provision are.  The letter to be charges that es continue.  The letter to be charges that es continue.  Inical record number of the provision service A viewed and fare ay occur for sence benefit.  Inical record number of the provision service A viewed and fare ay occur for sence benefit.  Inical record number of the provision service A viewed and fare ay occur for sence benefit.	end of that five (5) day t heard from you, we will your decision " ealth Advance Beneficiary	G 11		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC	- <b>I</b>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	1 10/	13/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  BY THE PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			(X5) COMPLETION DATE			
G 114	insurance benefit.  7. Clinical record nur Admission Service Agwas reviewed and fai that may occur for se insurance benefit.  8. Clinical record nur Admission Service Agwas reviewed and fai that may occur for se insurance benefit.  9. Clinical record nur Admission Service Agwas reviewed and fai that may occur for se insurance benefit.  9. Clinical record nur Admission Service Agwas reviewed and fai that may occur for se insurance benefit.  10. An undated polic indicated, "A Service developed with all clicare is provided. The identify the services to providing care, charg reimbursement for se informed of their liabilicare is provided, the c. The fees for services Medicaid or any other the agency f. The have to pay. g. Any admission and dischasshall be advised, of a frequency of services	mber 7, SOC 08/05/15. The greement dated 02/04/15, led to evidence the charges rvices not covered by the mber 8, SOC 09/08/15. The greement dated 10/30/14, led to evidence the charges rvices not covered by the mber 9, SOC 09/30/15. The greement dated 04/03/14, led to evidence the charges rvices not covered by the mber 9, SOC 09/30/15. The greement dated 04/03/14, led to evidence the charges rvices not covered by the vittled "Service Agreement" Agreement shall be ents upon admission, before a service agreement will to be provided, disciplines es and exprected sources of rvices. The client will be lity for payment 2. Before client shall be advised of tess. d. The extent to which may be expected from or third party paer known to charges the individual may limitations on service and arge criteria 4. The client	G	114			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		15K131	B. WING				C 13/2015
	ROVIDER OR SUPPLIER	NC		10	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	101	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 114 G 118	soon as possible, but days from the date the a a change " 484.12(a) COMPLIAN	e 4 e verbal and in writing as no later than, 30 calendar e agency becomes aware of NCE WITH FED, STATE,		114			
	services in complianc State, and local laws applicable local law p HHAs, an agency not	must operate and furnish e with all applicable Federal, and regulations. If State or rovides for the licensure of subject to licensure is sing authority as meeting shed for licensure.					
	Based on record revi update their policy to	not met as evidenced by: ew, the agency failed to reflect per 410 Indiana 17-2-1-(d) for 1 of 1 agency.					
	Nursing" indicated, " Minimum one [1] year 2. The 410 Indiana A (d) indicated, "A phys who has two (2) years at least one (1) year administrative experied direct nursing and oth The agency failed to the surface of	Administrative Code 17-2-1- ician or a registered nurse is of nursing experience, with of supervisory or ence, shall supervise and her therapeutic services."  update their policy to reflect ursing must have at least					
G 121	484.12(c) COMPLIAN PROFESSIONAL STI		G	121			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K131	B. WING				C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	NC	I	1	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	101	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
G 121	professional standard	e 5 must comply with accepted ls and principles that apply shing services in an HHA.	G	121				
	Based on observation interview, the agency had been provided in infection control policing Center for Disease control policing Center for	failed to ensure services accordance with its own ies and procedures and the						
	Control" indicated, ". Tier One 2. Hands with blood or body flu are removed, betwee to prevent transfer of other clients or the er used for client care is	titled "Infection Prevention / Standard Precautions are washed if contaminated id, immediately after gloves in client, and when indicated microorganisms between invironment 6. Equipment properly cleaned and - use items are discarded						
	/ Exposure Control Pl maintain policies and clients with infectious diseases and for infer employees; these pol conform with OSHA r standards, local and s accepted standards of Instructions 1. Client	ction control practices by icies and procedures shall egulations, Accreditation state laws, and currently						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED					
		15K131	B. WING				C <b>13/2015</b>
	ROVIDER OR SUPPLIER	INC	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	101	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
G 121	delivery of client care skin care and dressin sterile or aseptic dress. Appropriate handling products f. Freque health care employed provision of direct clies oiled or contaminate removing gloves E control procedures in h. keeping the clieneat, and orderly. The off the floor and out of the f	as necessary during the . b. Appropriate wound and g techniques following using procedures. c. and disposal of waste ent hand washing by home es: Before and after the ent care After handling ed materials after nvironmental infection clude, but are not limited to ent's environment clean, ensi includes keeping supplies ef reach of children "  isease Control Standard ef, "IV. Standard Precautions e. IV.A.1. During the enter a void unnecessary en close proximity to the enth contamination of clean ental surfaces and ental surfaces or lifting ental dressings. IV.A.3.c. atient's intact skin (e.g., ental dressings. IV.A.3.c. atient's intact skin (e.g., ental dressings. IV.A.3.c. ental dressings and ental surfaces and ent	G	121			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(.	(X3) DATE SURVEY COMPLETED			
						С
		15K131	B. WING _			10/13/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
ALL AGES	S HOME HEALTH CARE	INC		1081 THIRD AVENUE, SW, SUITE # 5	5	
				CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
G 121	Continued From page	e 7	G 1	21		
G 121	that are used by patied delivery of patient car are moved in and out IV.B. Personal pro IV.B.2. Gloves. IV.B. can be reasonably arblood or potentially in membranes, nonintar contaminated intact s.  4. A home visit was r Director of Nursing or The Director of Nursing or The Director of Nursing wound care to the patrochanter, two areas heel. The Director of to her nursing bag an and placed them on the Director of Nursing the patient's boxes of returned to the patient began treatment with hands. During the fire Director of Nursing rescissors and removed nursing bag to retriev washing / sanitizing hursing then walked reapplied gloves with hands. After using a right trochanter woun placed the Q-tip with	ents, those used during re, and mobile devices that of patient rooms frequently rective equipment (PPE) 2.a. Wear gloves when it rectious materials, mucous of skin, or potentially kin could occur. "  made to patient #4 with the n 10/09/15 at 10:30 AM. Ing was observed providing tient's right and left on the left buttocks, and left Nursing was observed to go d remove a pair of gloves the patient's bedside table. Ing then began to go through out washing / sanitizing her at dressing supplies and out washing / sanitizing her at dressing change, the salized she didn't have her d her gloves and got into her e the scissors without ter hands. The Director of back to the patient and out washing / sanitizing her Q-tip to tuck the kerlix in the d, the Director of Nursing the remaining kerlix and p while tucking the kerlix to	G 1	21		
	Nursing failed to disp a new Q-tip for the le the Director of Nursin Director of Nursing re	ose the used Q-tip and used ft trochanter wound. Once g got to the left heel, the moved her gloves, used proceeded to wipe her hands				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K131	B. WING			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COD 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 121	air. The Director of N boxes of dressing suppatient and reapplied sanitizing her hands. dressing change to th Nursing removed her and proceeded to wipagain, failing to allow After the Director of N assessment, the Direpatient's home, leaving on the patient's fi was interviewed during his / her routine nurse and disposes it for him 5. On 10/09/15 at 09 Nurisng stated that slid dressings changes be did a good job.	o allow her hands to dry by Jursing went back to the pplies, returned to the gloves without washing / Upon completion of the ne left heel, the Director of gloves, used hand sanitizer, be her hands on her jeans her hands to dry by air. Jursing completed her ector of Nursing left the ng the soiled dressings in a loor, opened. The patient ng this time and stated that he takes the soiled bag out m / her.  1:30 AM, the Director of the may not be proficient with jut she felt that she generally		121			
	Based on record revagency failed to ensuincluded the name of title / position from the patient for 1 of 1 agerensure that a quality performance improve implemented since the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED			
		15K131	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		10/13/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPENDED TO	IOULD BE	(X5) COMPLETION DATE
G 122	home health aide regirecords reviewed, fail made, wound treatment followed in accordance of 9 records reviewed treatments were admit as ordered by the phyreviewed on patients prepared and knowled treatment and assess observed and failed to document a patient's reviewed of patients with G 133); and failed to person was put into phyreviewed and competer patient care and the control of the	checks, and verification of a sistery for 3 of 5 personnel ed to ensure visits were ent and management was see to the plan of care for 4 standard for 2 of 2 records with wounds, failed to be digeable in providing wound sment for 1 of 1 home visits to completely assess and wound for 2 of 3 records with wound treatments (See ensure that a qualified place for the Director of failed to ensure that to place was properly at to assist the staff with lay to day operations of the by Centers for Medicare	G 1	22		
G 123	resulted in the agency with the Condition of I Organization, Service 484.14 ORGANIZATI ADMINISTRATION Organization, services control, and lines of a	s, and Administration. ON, SERVICES & s furnished, administrative uthority for the delegation of the patient care level are	G 1	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		15K131	B. WING _				C <b>13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CO 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
G 123	Continued From page	e 10	G ·	123			
G 133	Based on record revito ensure the Organizaname of the employe from the President do agency.  Finding included:  1. On 10/08/15, the oprovided by the Admichart provided indicate to include the name oposition.  484.14(c) ADMINIST  The administrator, which supervising physician under paragraph (d) of directs the agency's congoing liaison among		G	133			
	Based on record revobservation the agen administrator organiz quality assessment a improvement program survey; a system to e	ncy failed to ensure the zed and implemented a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		15K131	B. WING _			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/10/2010	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 133	home health aide reg records reviewed (dir C and E); a system to completed, wound tre was followed in accord 5 of 9 patients sampl system to ensure 1 o observed (director of visit of a patient with knowedgeable and or treatment and assess ensure nursing was of	checks, and verification of a istry in 3 of 5 personnel ector of nursing, employee of ensure clincal visits were eatment and managment redance to the plan of care for ed (Patient #1, 2, 3, 5, 7); a f 1 staff registered nurse nursing) during 1 of 1 home wounds (patient #4) was competent in providing wound sment; and a system to competent in assessment f wounds in 2 of 4 patients	G *	133			
	dated April 20, 21, 22 agency had to put a p May 20, 2015. The o limited to:  a. Weekly monit visits and verification documentation of mis the patient's physicia  b. Staff in-servic nutritional requirement  c. The profession in-serviced on the reco	ssed visits and notification of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING		10/13/20	15
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/20	15
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) PLETION DATE
G 133	for reviewing patient orders on a weekly b physician's order for each patient to preve deficiency.  e. The Director for monitoring patient other professional stapatient needs and inschanges in regard to plan.  f. The professional stapatient needs and inschanges in regard to plan.  f. The professional stapatient of decorrectness in regard to plan.  f. The professional stapatient of decorrectness in regard to plan.  There was no document recurrence of the stapatient of decorrectness in regard to prevent recurrence of the stapatient of the stapatien	of Nursing will be responsible care plans and physician's asis and securing care changes as needed on an recurrence of this  of Nursing was responsible at care and conferencing with aff to determine specific stituting the appropriate the home health aide care  anal staff was in-serviced on etailed documentation and les to medication profile. The will be responsible for admissions, resumption of and 60 day certifications to find this deficiency.  The ent to review to support evelop, implement, maintain, y assessment and ement program.  The Director of Nursing on M, stated that she is in the not spend a large amount of	G 13	33		
	June 1, 2015 and that Nursing stepped down the field.  3. An interview with	at the former Director of n to be a per diem nurse in the Administrator on				
		stated that the Director of Imissions, recertifications,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		15K131	B. WING			10/	13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		10	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 133	Nursing is responsible was not able to produce The administrator also had a QAPI meeting is the initial licensure suts.  B1. The Director of No6/10/15, personnel record had been done within of Nursing date of himprovide a second step 2. Employee C's, a him him of Nursing date of himprovide a second step 2. Employee E's, a him of Nursing date of himprovide a second step 2. Employee E's, a him of Nursing date of himprovide a second step 2. Employee E's, a him of Nursing date of himprovide a second step 2. Employee E's, a him of called to include a check.  3. Employee E's, a himployee E's, a himpl	the Administrator on stated that the Director of e for the chart audits but ace any audited material. To stated the agency has not to review audit findings since are since.  It is a provided a PPD upon hire. If alled to evidence a PPD and 12 months of the Director e. The agency failed to provide to PPD.  In a provided a PPD upon hire agency failed to evidence a PPD and 12 months of the Director e. The agency failed to provide a criminal background  It is a provided to provide a provide a criminal background  It is a provided to provide a criminal background  It is a provide to provide a provide a criminal to provide a	G	133			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 133	and home health aid and two hours in the Patient diagnoses in to: cerebral vascular hemiplegia, depress ulcers, and diabetes to apply non-adherer kerlix or similar prod reapply and evaluate a. Review of the indicated there were between 07/20/15 to made one extra visit visits during week two visits during week two visits during week for nurse failed to follow 1. Skilled in 08/05/15, indicated the back from the physic was being developed include treatment prothat the spouse was the wound.  2. Skilled in 08/12/15, indicated the wound.  2. Skilled in 08/12/15, indicated the wound.  3. Skilled in 08/13/15, failed to in educated on the main of the wound after applications of the wound after applicat	e three hours in the morning evening, 7 days a week. cluded but were not limited accident [stroke] with ion, lymphadema, stasis. Treatment orders indicated at dressing and secure with fuct and to teach husband to exwound progress weekly.  e skilled nursing notes no skilled nursing visits 08/03/15, the skilled nurse during week one, two extra ion, and no skilled nursing fur, five, and six. The skilled	G 1	33			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			C <b>0/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u> </u>	0/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORREST TO THE APPOPULATION DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 133	b. Review of the notes indicated there visits between 07/20/were missed on 08/0 08/16, 08/17, 08/19, 09/08, 09/09, 09/10, were missed on 08/0 08/22 (only 1 hour pr 08/27, 08/31, 09/01, 09/09, 09/10, and 09 combined in one visit PM), 08/08 ( 9:00 AM AM - 2:30 PM), 08/18 (9:00 AM - 1:15 PM).  2. Clinical record of was reviewed and incestablished by a physof 05/14/15 to 07/13/nursing one time a w medication set up, howeek for nine weeks.  a. Review of the indicated the skilled in nursing visit during week one.  3. Clinical record of was reviewed and incestablished by a physological point of the indicated the skilled in nursing visit during week one.	ursing visit note dated dicate if the spouse was nagement of the wound.  Home Health aide visit were no home health aide (15 to 08/03/15, AM visit 5, 08/07, 08/14, 08/15, 08/23, 08/30, 09/03, 09/07, and 09/11/15. PM visits 6, 08/10,08/15, 08/16, 08/17, ovided), 08/24, 08/25, 08/26, 09/02, 09/03, 09/07, 09/08, 711/15. Visit hours that were to no 08/04 (9:30 AM - 2:30 M - 1:00 PM), 08/18 (10:30 PM), and 08/20 Patient #3, SOC 11/13/14, cluded a plan of care sician for certification period 15, with orders for skilled eek for 9 weeks for omemaker one hour per session when the second of th	G 13	33		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		OMPLETED
		15K131	B. WING _			C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	•	10.10.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 133	nursing two to three to assess, medication health aide supervishealth and home her four hours a day, three assist with personal complete bath or shown assist between 07/31  b. The clinical of the clinical o	times a month for two month on compliance, safety, home ion, assess patient's overall alth aide services three to ree to five days a week to care to include partial to ower, shampoo, skin care, the housekeeping to help safe environment.  e skilled nursing notes were to evidence skilled nursing /15 to 09/18/15.  record was reviewed on M. A physician order dated 'HHA [home health aide] ours per day, three to five [Physical therapy] to restore refollowing clinical findings, with household transfers, reakness limiting ability to a Require strength training. The home health aide can of the home health aide visit to 12:00 PM, indicated there in aide visits between 5.  Indicated physical therapy had resessment of the patient in plan of care, nor had in for the home health aide	G 1	33		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING _			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 133	available at this time aid visits notes, indical started seeing the on 09/13/15. The hot follow the plan of care.  c. An interview 10/13/15 at 12:20 PM not start services untauthorization was ap C4. Clinical record # plan of care establish certification period of with orders for skilled monthly for medicatic Review of the skilled evidence skilled nurs 09/10/15.  C5. Clinical record # plan of care establish certification period of orders for skilled nurs 09/10/15.  C5. Clinical record # plan of care establish certification period of orders for skilled nurs 109/10/15.  a. Review of the indicated that the ski visit during week one follow the plan of care.  b. Review of the indicated that the hot services until week to services until services until services until services until services until serv	weekend coverage not "Review of the home health ated that the home health e patient for one hour per day me health aide failed to e.  with the Administrator on M, stated that the patient did il after the medicaid prior proved.  77, SOC 08/05/15, included a ned by a physician for 108/05/15 to to 09/30/15, I nursing one to four times on set up and assessment. nursing notes, failed to ing visits 08/05/15 to  19, SOC 09/30/15, included a ned by a physician for 109/30/15 to 11/26/15, with sing one time a week for e health aide services three hree to five days a week for e skilled nursing visit notes lied nurse made an extra e. The skilled nurse failed to	G 1	33			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING		C 10/13/2015	
	ROVIDER OR SUPPLIER	E INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION	
G 133	C6. The Administra further documentation regarding the finding exit conference on 207/20/15, include a physician for certification 10/03/15, with order a week for wound concluded cerebral valued hemiplegia, depressucers, and diabetes to apply non-adhere kerlix or similar producers, and diabetes to apply non-adhere kerlix or similar producers, and diabetes to apply non-adhere kerlix or similar producers.  b. Skilled nurse waterproof non-adh skilled nurse failed to order.  b. Skilled nurse wound to the 2nd to identified on 08/05/20 obtain an order for twound on the left for D2. Clinical record plan of care establis start of care date of periods 08/06/15 to 11/07/15 with orders wet to dry dressing hips."	tor was unable to provide any on and / or information gs referenced above by the 10/13/15 at 3:50 PM.  #1, SOC (start of care) plan of care established by a ation period of 08/03/15 to s for skilled nursing one time are. Patient diagnoses ascular accident [stroke] with sion, lymphadema, stasis at Treatment orders indicated and dressing and secure with duct.  Ing visit note dated 08/12/15, dressed the wound with a esive edge gauze. The ofollow the current treatment of the left foot that was 15. The skilled nurse failed to reatment of the 2nd toe ot.  #4, SOC 08/04/15, included a shed by a physician with a 08/06/15 and certification 09/25/15 and 09/26/15 to s for skilled nursing daily for changes to "decubes both	G 13			
		me visit on 10/09/15 at 10:30 Nursing was observed to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		OMPLETED
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	•	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 133	the left trochanter ar and left trochanter, I Nursing was observed tips and wound clewith 4 x 4 gauze, sput three times to an an traditional kerlix, as firmly packed the rigulation between the covered all wounds the dressings with h Nursing was also obwith wound cleansed secured with cover the Director of Nursi of the treatments be Registered Nurse, where the patient had a lain his bedroom.  b. The clinical in 10/09/15 at 1:30 PM note dated 10/03/15 observed the patient between the left but description provided slough but no draina dated 10/04, 10/05, indicated Employee by cleansing the worth and reference in the second to the treatments between the left but description provided slough but no draina dated 10/04, 10/05, indicated Employee by cleansing the worth and the second the second treatment of the second t	change to an area between and buttock, as well as the right eft buttock, The Director of ed to clean the wounds with eanser, wiped the wounds rayed wound cleanser two to timicrobial kerlix vs the instructed by the patient, and ht / left trochanter and left blied the same kerlix to the left buttocks and trochanter, with ABD pads, and secured ydrofilm. The Director of isserved to clean the left heal r, applied a dry dressing and roll. During the observation, and confirmed with the patient ing done by Employee H, a ray ho routinely sees the patient. The box of antimicrobial kerlix record was reviewed on the to have a new wound rocks and left trochanter. The indicated the wound had rocks and left trochanter. The indicated the wound had rocks and left trochanter. The indicated the wound treatment and with wound cleanser, all saline wet to dry dressing	G 1	33		
	08/29/15, 09/03/15 t 10/09/15, indicated	ng visit notes from 08/06/15 to o 09/18/15, and 09/26/15 to the right / left trochanter and were being cleaned with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K131	B. WING				C 13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			1	STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	1 10/	13/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 133	saline wet kerlix, then secured with hydrofiln left heel was being cleanser, 4 x 4 normal coverall to secure.  The Director of Nursing providing specific wow wound cleanser, antir hydrofilm to the right buttocks without a ph Director of Nursing ar providing wound treat area between the left well as the left heel w.  D3. The Administrate further documentation regarding the findings exit conference on 100 divided to comply the services provided to comply the services provided to comply the services of Rule 2. Refull and Administrative Responsible to apply 1. The registered nurseless the patient / corganized manner provide for patient / corganized manner ar linitiate nursing action to maximize his or heep coverage.	and being pack with normal at 4 x 4, ABD padding, and an transparent dressing. The eansed with wound all saline wet to dry, and and Employee H was und treatments, such as microbial kerlix, ABD, and a left trochanter and left ysician's order. The end Employee H was treatments to the new pressure trochanter and buttock as without a physician's order.  For was unable to provide any and and a for information are referenced above by the end at 13.15 at 3:50 PM.  For titled "Physician Orders" trochanter and buttock as without a physician order.  For was unable to provide any and and a referenced above by the end at 13.15 at 3:50 PM.  For titled "Physician Orders" trochanter and buttons, treatments a	G	133			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C 1 <b>0/13/2015</b>	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARI	E INC		STREET ADDRESS, CITY, STATE, ZIP CO 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	DDE	37 13/20 10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 133	knowledge and skill competence in nurs professional growth Responsibility as a profession. Sec. 1. the following: (1) Fi boundaries of nursinknowledge of statut nursing. (2) Accep nursing actions and Communicate, colla other members of the and effective care. Supervision as necen nursing practice ted. Unprofessional combehaviors (acts, knowledge of statut nursing practice ted. Unprofessional combehaviors (acts, knowledge of statut nursing practice ted. Unprofessional combehaviors (acts, knowledge of statut nursing practice ted. Unprofessional combehaviors (acts, knowledge of the minimal prevailing nursing propardize the healt public, shall constitut. These behaviors show the following: (1) technical skills, or in providing nursing can ursing technique of nurse is unprepared nurse is unprepared start of care establis start of care date of periods 08/06/15 to 11/07/15 with orders wet to dry dressing hips."	ance and maintain current is for his or her continuing ing practice and individual.  848 IAC 2 - 2 - 2 member of the nursing The registered nurse shall do unction within the legal ing practice based on the es and rules governing to responsibility for individual continued competence.  (3) aborate, and function with the health team to provide safe (4) Seek education and essary when implementing thingues 848 IAC 2 - 2 - 3 duct Sec. 3. Nursing powledge, and practices) failing is standards of acceptable and	G 1	33			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		15K131	B. WING				13/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
ALL ACE	NOME HEALTH CARE	INC		1	081 THIRD AVENUE, SW, SUITE # 5		
ALL AGES	S HOME HEALTH CARE	INC		c	CARMEL, IN 46032		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
G 133	Continued From page	e 22	G	133			
	· -	of Nursing, the patient was					
		ound to the right and left					
		k, an area between the left					
	· ·	ittock, and left heel. The					
	Director of Nursing pr	roceeded to ask the patient					
		ng to be used. The patient					
		rector of Nursing to use an					
		roll and directed the Director					
		ation of the dressing. After					
		kerlix roll, the Director of					
		nove items around on the ked the patient where was					
		that she may measure his					
	_	ed to tell the patient that he /					
	-	lk her through the dressing.					
		left trochanter and left hip					
		e IV and large in size in					
	regards to length and	I width. The Director of					
	_	d to place a Q-tip on 4 x 4					
	_	leanser and sprayed over the					
		to clean the wound with the					
		the wound bed with the 4 x					
		or of Nursing then proceeded					
	•	hovered over the wound over top of the measuring					
		rage, then placed the Q-tip in					
		kerlix dressing. The patient					
		e undermining and tunneled					
		unds and the Director of					
	Nursing failed to mea	sure the undermining and					
	tunneled areas.						
	The Director of N	Nursing then proceeded to					
	ask the patient if the						
		ent informed the nurse yes					
		of Nursing that Employee H,					
		d Nurse / Case Manager,					
	_	o moistened the gauze. The					
	Director of Nursing pi	icked up a bottle that was					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		15K131	B. WING			l	13/2015
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	081 THIRD AVENUE, SW, SUITE # 5		
ALL AGES	S HOME HEALTH CARE	INC		c	CARMEL, IN 46032		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATORTOR	EGG IDENTIL TING INI GRANATION)	TAG		DEFICIENCY)	NIL.	
G 133	Continued From page	e 23	G	133			
	labeled "Derma Gran	Wound Cleanser" and					
	informed surveyor that	at the bottle was Normal					
	Saline. The Director	of Nursing then squirted the					
		nes with the wound cleanser					
	and proceeded to page	ck the right wound firmly with					
		Q-tip that was used for					
		ng the right wound, the					
		sked the patient if the ABD					
		ut the patient instructed the					
	_	at the 4 x 4 gauze came					
		to tell her how much 4 x 4					
		he kerlix packing. The					
		nen placed the ABD and then					
		truct the Director of Nursing					
		nydrofilm covering. The roceeds to follow this same					
	_	on to the left sided wounds,					
	•	and asking for direction and					
		itient. During the packing of					
		nt made facial expressions of					
	_ ·	ent had to inform the Director					
		wound located between the					
	_	ittocks. The Director of					
	Nursing stated she ha	ad not noticed the wound					
	and thanked the patie	ent for pointing the wound					
	out. Moving to the le	ft heel, the Director of					
	Nursing asked the pa	tient what the treatment was					
		s to the area. The Director					
	· • •	to to ask the patient if					
		gauze and asked the					
	-	or which to place the gauze.					
		sing change, the Director of					
		comment on her lack of					
		e dressing change correctly					
		he patient more often, she					
	would be more profic	repared, demonstrate and					
	verbalize competence						
	verbalize competence	c or would care.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		15K131	B. WING			C 0/13/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		0/13/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
G 133	Nursing asked the p drainage on the dres removed prior to our Nursing failed to eduremove the dressing a bag so that the regard the dressings for signormal bags of the dressing wound as comprehensive associated the right "h 2 cm (centimeters), and 4 x 4 cm. The lemeasured.  c. A skilled nursum as a company of the dressing wounds was measured as x 8 x 3 cm and or x 3 cm. The second failed to be measured document if the physignificant increase in d. A skilled nursum as a x 4 x 2 and 5 x 4 x measured 2 x 2 x 0.3 to document if the physignificant increase in e. A skilled nursum as a skilled nurs	treatments, the Director of atient what color was the sings that he / she had arrival. The Director of acate the patient not to as or to save the dressings in gistered nurse may observe ans of odor and infection.  The coord of patient #4's was 5 at 1:15 PM. The Director assessment on the start of care assessment dated 08/04/15, aip" wound measured 7 x 5 x left hip wounds 5 x 4 x 2 cm aft heal failed to be  The right hip measured are of the left hip wounds 5 x 6 hip wound and left heal and. The nursing note failed to sician was notified of the an size of the right hip wound.  The right hip wounds 5 cm. The left heel and cm. The left hips measured are of the left hips measured are of the left hips measured are of the right hip wound.  The right hip wounds 5 cm. The left heel are of the right hip wound.  The right hip wounds 5 cm. The nursing note failed any sician was notified of the notice of the right hip wound.	G 13	33		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K131	B. WING			·	C <b>13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE I	INC	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	107	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 133	to document if the physignificant increase in f. A skilled nursii 08/24/15, by Employe measured 17 x 15 x 3 3 x 3 x 2.1 cm, 4 x 4 x measured 1.5 x 1 x 2 failed to document if the significant increase wound.  g. The patient w 08/30/15 to 09/02/15. comprehensive assess performed by the Direct documented wound a exact same description the start of care computed to 408/04/15.  h. An note in the 09/04/15, was entered entry indicated that E report that patients he and was resuming the heel as ordered."  i. Review of the dated 09/05/15 to 09/included / documented treatments.  j. A skilled nursin 09/07/15, by Employe measured 17 x 15 x 22	cm. The nursing note failed ysician was notified of the a size of the right hip wound.  In a size of the right hip wound wound.  In a size of the right hip wound wound was notified of the physician was notified the wet to dry dressings to left would be wet to dry dressings to left wound woun	G	133			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K131	B. WING		C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARI	E INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10.10.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETION
G 133	09/18/15, by Emplo measured 18 x 14 x 15 x 14 x 2 cm and wound failed to be r failed to document i the significant increwound.  I. The patient v to 09/25/15. The cli comprehensive ass	rsing visit was made on yee H. The right hip as 3 cm, the left hips measured 8 x 9 x 3 cm. The left heal measured. The nursing note of the physician was notified of ase in size of the right hip was hospitalized from 09/19/15 inical record failed to include a essment upon return from the yound measurements and	G 133		
	m. A skilled nu 10/3/15, by Employ the patient had a "d no drainage and fail of the new wound, a tissue. Skilled nurs 10/02/15, failed to it developing a pressu skin on 10/03/15.	ersing visit was made on ee H. Employee H indicated ecube open It [light slough], led to provide measurements appearance of surrounding ing visits from 09/26/15 to indicate that the patient was are ulcer prior to eruption of			
	10/04/15, by Emplo measured 12 x 10 x 10 x 2 cm and between the left "hip cm. The left heel m o. A skilled nur 10/09/15, by the Dir hip measured 6 x 4 measured 6 x 5 x 3 wound between the	rsing visit was made on yee H. The right hip a 3 cm, the left hips measured 7 x 4 x 2 cm. The new area cos" measured 2.5 x 2.5 x 2 measured 1 x 1 x 0.1 cm.  The right hips measured 2.5 x 2.5 x 2 measured 1 x 1 x 0.1 cm.  The right x 3 cm, the left hips cm and 4 x 2 x 3 cm. The two left "hips" measured 3 x 2 off theel measured 2 x 2 cm.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		15K131	B. WING		C 10/13/2015
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  B. WING  AME OF PROVIDER OR SUPPLIER  LL AGES HOME HEALTH CARE INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032			
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
G 133	The Director of Nursi her measures, label to correctly, as per prevent performed by Employ Skilled nursing visit in 08/29/15, 09/04/15 to 10/08/15, Employee were light pink with we partial granulation. Education to document specific dethat provides location white tissue and slou appearance of surrous wound.  E3. Clinical record # plan of care establish certification period of orders for skilled nursine weeks to evaluate or healing and possi evaluate ulcer on right progression to healing increase size.  a. Review of the comprehensive assee M1330 under the Internet the patient had a state unobservable and M had an observable signanulating. The confailed to include local the surgical incision a of the stasis ulcer an unobservable.	ing failed to be accurate in the left hips and heel wound rious measurement yee H.  Inotes dated 08/06/15 to 0.09/18/15, and 09/26/15 to H, indicated that the wounds white - yellow slough tissue or employee H failed to be escriptions for each wound in and percentage of pink to gh, as well as the unding skin around each  19, SOC 09/30/15, included a need by the physician for the 09/30/15 to 11/26/15, with sing one time a week for the left below the knee stump ble skin breakdown and in the "bk" [below the knee] for gor non healing and  10 OASIS start of care is sment dated 09/30/15, regumentary Status, indicated is sulcer that was 1340 indicated the patient turgical wound that was fully in prehensive assessment tion, size, and description of	G 133		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_			
		15K131	B. WING			10/	13/2015
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALL AGES	HOME HEALTH CARE I	NC			081 THIRD AVENUE, SW, SUITE # 5		
				C	ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 133	wound to the right toe assessment of the su indicated in the comp  E4. The Director of N 10/09/15 at 11:45 AM stated that she had no November, 2014 and nurse for many years  E5. The Administrator 10/09/15 at 1:30 PM. Employee G, the form stepped down to be a on an as needed basi Employee G or Employate G	e patient had an open but failed to include an rgical wound that was rehensive assessment.  Iursing was interviewed on The Director of Nursing of worked as a nurse since she had been an infusion  r was interviewed on The Administrator stated her Director of Nursing, had case manager in the field as and she was not sure if oyee H, a Registered Nurse, ills check off with the current  Iursing personnel record 13/15 at 3:00 PM. The dicated in her proficiency of	G	133			
	=	ed to include a skills check re by the agency after the as hired.					
G 134	Services", indicated "	y titled "Skilled Nursing The registered nurse uiring specialized nursing RATOR	G ·	134			
		o may also be the or registered nurse required of this section, employs					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		15K131	B. WING			C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COI 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 134	education and evalua	nd ensures adequate staff ations.	G 13	34		
	Based on observation interview, the Administration qualified person was Director of Nursing potential whoever was put trained and competer patient care and the observations.	not met as evidenced by: on, record review and strator failed to ensure that a put into place for the osition and failed to ensure t into place was properly nt to assist the staff with day to day operations of the by Centers for Medicare				
	The clinical record incestablished by a physical of 08/03/15 with a certo 10/03/15, with order time a week for wound ordered on the plant of skilled nurse to apply secure with kerlix or state of the secure with kerlix or state of the secure with the secure with kerlix or state of the secure with	red on 10/08/15 at 2:30 PM. cluded a plan of care sician for a start of care date rtification period of 08/03/15 ers for skilled nursing one ad care. The treatment of care indicated for the ronn-adherent dressing and similar product.				
	07/20/15. The Direct update the plan of ca of care date of 07/20/ of 07/20/15 to 09/17/ failed to include the k	d consents for treatment on or of Nursing failed to re to reflect the correct start /15 and a certification period 15. The Director of Nursing ocation of the patient's the wound, and frequency of the plan of care.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		` ′	OATE SURVEY OMPLETED
		15K131	B. WING			C
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		10/13/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
G 134	assessment dated 08 Plan of Care Synops ordered plan of care Diabetic foot care inco presence of skin lesic and patient / caregive care - yes, c. Falls p d. Depression interv referral for other treat or current treatment a that patient screened yes, e. Interventions - yes, f. Interventions - yes, f. Interventions yes " The Directo the plan of care to inc f.  c. An OASIS sta assessment dated 08 location and size of v to complete vital sign assessments, comple assessment, neuro / assessment, failed t screening score of 6 indicate if the patient nursing services, faile any management of 24 hr supervision / cl transfers / infection c safety measures, and instructions / materia of the assessment fa provided during the a of Nursing failed to ce	art of care comprehensive 3/03/15, indicated "M2250 is Does the physician - include the following b. duding monitoring for the ons on the lower extremities er education on proper foot revention interventions - yes, entions such as medication, tment, or a monitoring plan and / or physician notified positive for depression - to monitor and mitigate pain at to prevent pressure ulcers - or of Nursing failed to update clude interventions listed b - art of care comprehensive 8/03/15 failed to include the nutritional status, elimination, abdomen emotional / behavioral status to address the depression with the physician, failed to was receiving psychiatric and to include the ear pathways / lock w/c with ontrol measures under	G 1	34		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		15K131	B. WING			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	•	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
G 134	Continued From pag	ge 31	G 13	34		
	indicated "see attack Director of Nursing f listed on the medica was taking / prescrib.  2. The clinical record o7/29/15, was review The clinical record in established by a phy 07/29/15 to 09/05/15 with orders for skille times a week for nin aide visits for assistate preparation, medical keeping to maintain environment.  a. The Director plan of care to reflectives on the medical care to reflect the medical care the medical care to reflect the medical care to reflect the med	ion portion of the plan of care ned medication profile." The ailed to include medications tion profile that the patient ped on the plan of care.  Id of patient #2, SOC wed on 10/08/15 at 3:45 PM. Included two plans of care visician for certification period of and 09/05/15 to 10/31/15, id nursing visits one to two weeks and home health ance with personal care, meal tion reminder and light house a safe and clean  Of Nurse failed to update the of the correct certification 109/26/15 and 09/27/15 to				
	b. The Director the frequency and d visits, as well as the home health aide we certification periods.  c. Review of th indicated a recertific completed on 09/05, period was 07/29/15 Nursing failed to cor assessment within the day episode.	of Nursing failed to include uration of home health aide type of personal care the ere to provide for both  e skilled nursing visit notes ation assessment had been 15. The correct certification to 09/26/15. The Director of inplete the recertification he last 5 days during the 60 made to patient #4 on				

NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC   (X4) ID PREFIX TAG  G 134  Continued From page 32 10/09/15 at 10:30 AM, with the Director of Nursing. During the home visit, the patient was observed to place a wound to the right and left trochanter, left buttock, and left heel. The Director of Nursing proceeded to tak the patient had instructed the Director of Nursing proceeded to tak the rhing of the location of the dressing. After obtaining the special kerlix roll, the Director of Nursing proceeded to tak the rhing than defit trochanter, left buttock, and left the dressing. The patient where was the measuring tool so that she may measure his wounds and proceeded to talk her through the dressing. The patient fight and left trochanter and left thing on the patient where was the measuring tool so that she may measure his wounds and proceeded to talk her through the dressing. The patient fight and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the Q-tip, and proceeded to clean the wound with the Q-tip and then wipped the wound bed with the 4 x 4 gauze. The Director to Nursing then proceeded to take the Q-tip and then wipped the wound bed with the 4 x 4 gauze, then placed the Q-tip to the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the kerixit dressing. The patient in the package with the wound bed with the dressing. The patient in the package with the dressing. The patient in the package with the dressing. The patient in the package with the dressi		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC  (XM-1) (M-1) (M-1				A. BOILD		<del></del>	، ا	<u></u>
NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC   (X4) ID PREETIX TAG  (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (CACH DEFICIENCY)   PREFIX CARMEL, IN 46032  CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH DEFICIENCY)  (CACH DEFICIENCY MUST BE PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICE TO THE APPROPRIATE TO THE APPROPRIATE DEFICE TO THE APPROPRIATE DEFICE TO THE APPROPRIATE TO THE APPROPRIATE TO THE TAGE  (CACH CORRECTIVE ACTION TO THE TAGE TO THE APPROPRIATE TO THE TAGE TO THE TAGE TO THE T			15K131	B. WING				-
1081 THIRD AVENUE, SW, SUITE # 5   CARMEL, IN 4029    CARMEL IN 4029    FREETX TAG   SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG     FROM THE APPROPRIATE   PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG     G 134   Continued From page 32   10/09/15 at 10:30 AM, with the Director of Nursing. During the home visit, the patient was observed to have a wound to the right and left trochanter, and left buttock, and rea between the left trochanter, left buttock, and rea between the left trochanter and left buttock, and left heel. The Director of Nursing proceeded to ask the patient on the type of dressings to be used. The patient had instructed the Director of Nursing of the location of the dressing. After obtaining the special kerlix roll, the Director of Nursing proceeded to make the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 qauze. took wound cleanser and sprayed over the Q-tip, and proceeded to clean the wound with the Q-tip and then wiped the wound bed with the 4 x 4 qauze. The Director of Nursing then proceeded to talk the Q-tip and hovered over the wound then placed the Q-tip over top of the measuring tool on the 4 x 4 package, then placed the Q-tip in the package with the kerlix dressing. The patient	NAME OF P	ROVIDER OR SLIPPLIER			S	TREET ADDRESS CITY STATE ZIP CODE	10/	13/2013
ALL AGES HOME HEALTH CARE INC  (X4) ID (X4) ID (EACH DEFICIENCY) MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION)  G 134  Continued From page 32 10/09/15 at 10:30 AM, with the Director of Nursing. During the home visit, the patient was observed to have a wound to the right and left trochanter, left buttock, an area between the left trochanter, left buttock, an area between the left trochanter and left buttock, and left heel. The Director of Nursing proceeded to ask the patient had instructed the Director of Nursing to use an AMD Anatomic kerlix roll and directed the Director of Nursing proceeded to move items around on the bedside table and asked the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the Q-tip, and proceeded to clean the wound with the Q-tip and throwerd over the wound then placed the Q-tip over top of the measuring tool on the 4 x 4 package, then placed the Q-tip in the package with the keriki dressing. The patient								
CALL   DEPTICIENCY   SUMMARY STATEMENT OF DEFICIENCIES   DEPTICIENCY MUST BE PRECEDED BY PILL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   COMPLETION ON TAG      Continued From page 32   10/09/15 at 10:30 AM, with the Director of Nursing. During the home visit, the patient was observed to have a wound to the right and left trochanter, left buttock, an area between the left trochanter, left buttock, an area between the left trochanter and left buttock, an area between the left trochanter and left buttock, and left heel.   The Director of Nursing proceeded to ask the patient and instructed the Director of Nursing of the location of the dressing.   After obtaining the special kerlik roll, the Director of Nursing proceeded to move items around on the bedside table and asked the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the Q-tip, and proceeded to team the wound with the Q-tip and then wiped the wound then placed the Q-tip or yet of the measuring tool on the 4 x 4 package, then placed the Q-tip in the package with the kerik dressing. The patient	ALL AGES	S HOME HEALTH CARE	INC					
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  G 134  Continued From page 32  10/09/15 at 10:30 AM, with the Director of Nursing. During the home visit, the patient was observed to have a wound to the right and left trochanter, and left buttock, an area between the left trochanter and left buttock, an area between the left trochanter and left buttock, and left heel. The Director of Nursing proceeded to ask the patient on the type of dressings to be used. The patient had instructed the Director of Nursing of the location of the dressing. After obtaining the special kerlix roll, the Director of Nursing proceeded to move items around on the bedside table and asked the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the Q-tip, and proceeded to clean the wound with the Q-tip and then wiped the wound bed with the 4 x 4 gauze. The Director of Nursing then proceeded to take the Q-tip over top of the measuring tool on the 4 x 4 package, then placed the Q-tip in the package with the kerkix dressing. The patient		I				·		I
10/09/15 at 10:30 AM, with the Director of Nursing. During the home visit, the patient was observed to have a wound to the right and left trochanter, left buttock, an area between the left trochanter and left buttock, and left heel. The Director of Nursing proceeded to ask the patient on the type of dressings to be used. The patient had instructed the Director of Nursing to use an AMD Anatomic kerlix roll and directed the Director of Nursing of the location of the dressing. After obtaining the special kerlix roll, the Director of Nursing proceeded to move items around on the bedside table and asked the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the Q-tip, and proceeded to clean the wound with the Q-tip and then wiped the wound bed with the 4 x 4 gauze. The Director Nursing then proceeded to take the Q-tip and hovered over the wound then placed the Q-tip on the 4 x 4 package, then placed the Q-tip in the package with the kerlix dressing. The patient	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
was observed to have undermining and tunneled areas in all three wounds and the Director of Nursing failed to measure the undermining and tunneled areas. The Director of Nursing then proceeded to ask the patient if the kerlix needed to be moistened. The patient informed the nurse yes and told the Director of Nursing that Employee H, the routine Registered Nurse / Case Manager, used Normal Saline to moistened the gauze. The Director of Nursing picked up a bottle	G 134	10/09/15 at 10:30 AN Nursing. During the observed to have a varochanter, left buttook trochanter and left but The Director of Nursing patient on the type of patient had instructed use an AMD Anatom Director of Nursing of Nursing proceeded the bedside table and was the measuring to his wounds and proche / she would have dressing. The patier and left hip wounds wisze in regards to len of Nursing was obsergauze, took wound of Q-tip, and proceeded Q-tip and then wiped 4 gauze. The Director to take the Q-tip and then placed the Q-tip tool on the 4 x 4 pack the package with the was observed to have areas in all three wor Nursing failed to measure tunneled areas. The proceeded to ask the to be moistened. The yes and told the Dire Employee H, the rou Manager, used Normans and told the portion of th	Al, with the Director of home visit, the patient was wound to the right and left ck, an area between the left attock, and left heel. Ing proceeded to ask the fersings to be used. The difference to the difference of the Director of Nursing to ic kerlix roll and directed the fifthe location of the dressing. Decial kerlix roll, the Director difference to difference to difference of the dressing. Decial kerlix roll, the Director difference to differe	G	134	DEFICIENCY		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	NG _		Ι,	C
		15K131	B. WING				13/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALL ACE	NUME HEALTH OAF	TE INC		10	081 THIRD AVENUE, SW, SUITE # 5		
ALL AGE	S HOME HEALTH CAR	E INC		С	ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 134	Saline. The Direct kerlix gauze three and proceeded to perform and if she had seed would be more pro Nursing procedure and thanked the patient the direction. Throughout the direction of Nursing stated she and thanked the patient the direction. Throughout the direction of Nursing stated she and thanked the patient the direction. Throughout the direction of Nursing stated she and thanked the patient the direction. Throughout the direction of Nursing of the nursing asked the that Employee H wets to patient the direction. Throughout the direction of Nursing continued abilities to perform and if she had seed would be more pronursing failed to be verbalize competer wound treatments,	ege 33 Evyor that the bottle was Normal for of Nursing then squirted the times with the wound cleanser back the right wound firmly with the Q-tip that was used for cking the right wound, the asked the patient instructed the asked the patient instructed the that the 4 x 4 gauze came and to tell her how much 4 x 4 for the kerlix packing. The then placed the ABD and then instruct the Director of Nursing the hydrofilm covering. The proceeds to follow this same nion to the left sided wounds, and asking for direction and patient. During the packing of the tient made facial expressions of the attent had to inform the Director the wound located between the buttocks. The Director of had not noticed the wound left heel, the Director of patient what the treatment was to be to the area. The Director of the gauze and asked the infor which to place the gauze. The patient of the dressing change correctly in the patient more often, she ficient. The Director of the prepared, demonstrate and the of wound care. After the the Director of Nursing asked for was the drainage on the	G	134			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		15K131	B. WING _			C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 134	arrival. The Director the patient not to rer the dressings in a bar nurse may observe to odor and infection. This time. The patient the hospital in August two weeks prior, for patient stated he / stantibiotics in August antibiotics from the roa. The clinical record in established by a phy date of 08/06/15 and 08/06/15 to 09/25/15 b. The admission service was signed a 08/04/15. The correct of Nurse of care to reflect the certification periods.  c. The medicatic care indicated the part of the correct of the certification periods.	the had removed prior to our of Nursing failed to educate move the dressings or to save ag so that the registered the dressings for signs of The was interviewed during in that stated he / she was in stand again approximately a urinary tract infection. The ne was discharged with oral but was not discharged with eccent hospital stay.  The discharged with oral stay at 1:15 PM. Included a plan of care resician with a start of care of certification periods and 09/26/15 to 11/07/15.  The paperwork indicated the and dated by the patient on act certification periods were and 10/03/15 to 12/01/15. Ing failed to update the plan correct start of care date and an ion profile on both plans of atient was prescribed / taking a [milligrams], two capsules ally, and Bactrim DS 800 mg / The Director of Nursing current plan of care	G 1	34		
		f care provided orders for changes monthly. The				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		15K131	B. WING		10	C / <b>13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	,	, 10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 134	care to include interv	red From page 35  of Nursing failed to update the plan of include interventions for prevention of tract infections, and to include the size b inflation of the suprapubic catheter.				
	e. Review of the assessment dated 08 wounds to two areas the right hip, and an a treatment indicated whips." A resumption assessment dated 08 the wounds with wou soaked normal saline with a transparent dre Nursing failed to updathe accuracy of the lobeing treated, the tre wound, and the frequency that were to be preformed.	e start of care comprehensive 8/06/15, documented on the left hip, an area to area to the left heel. The vet to dry dressings to "both of care comprehensive 9/03/15, indicated to clean and cleanser, pack with kerlix e, apply ABD, then secure essing. The Director of ate the plan of care to reflect ocation of wounds that was atment provided to each tency of dressing changes rmed.				
	assessment dated 08 "hip" wound measure (centimeters), left hip x 4 cm. The Director measure the left heal g. The patient w 08/30/15 to 09/02/15 comprehensive asses performed by the Director documented wound a exact same description	tart of care comprehensive 8/04/15, indicated the right ed 7 x 5 x 2 cm wounds 5 x 4 x 2 cm and 4 of Nursing failed to				
	h. A skilled nurs	ing visit was made on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	COMPLETED		
		15K131	B. WING		10/	) 13/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	107	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 134	10/04/15, by Employ measured 12 x 10 x 3 10 x 10 x 2 cm and 7 between the left "hips cm. The left heel me  i. A skilled nursi 10/09/15, by the Dire hip measured 6 x 4 x measured 6 x 5 x 3 c wound between the t x 0.5 cm, and the left The Director of Nursi her measures, label the correctly, as per previous performed by Employ j. Review of the the Director of Nursir date of medication or date of drug regimen caregiver, and medic physician at the start drug regimen review upon recertification.  k. Review of the the Director of Nursir recertification assess during the 60 day epit 4. The clinical record in established by a physic of 07/31/15, was review The clinical record in established by a physic of 07/31/15 to to 09/11/05/15.	ee H. The right hip 3 cm, the left hips measured x 4 x 2 cm. The new area s" measured 2.5 x 2.5 x 2 easured 1 x 1 x 0.1 cm.  Ing visit was made on ctor of Nursing. The right 3 cm, the left hips m and 4 x 2 x 3 cm. The wo left "hips" measured 3 x 2 heel measured 2 x 2 cm. Ing failed to be accurate in the left hips and heel wound rious measurement ree H.  Indication profile indicated fing failed to include a start dered, potential side effects, review of the patient / fation reconciliation with the of care and failed to do a of the patient / caregiver  Eskilled nursing visit notes, fing failed to complete the sment within the last 5 days assode.  If for patient #5, SOC red on 10/13/15 at 12:00 PM.	G 13	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING		C 10/13/2015
	ROVIDER OR SUPPLIER	E INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
G 134	07/31/15. The Directory update the plan of of certification period of 09/29/15 to 11/27/1.  b. Review of the Director of Nurse date of medication of date of drug regime caregiver, and mediphysician at the standrug regimen review upon recertification.  c. Review of the Director of Nurse recertification assess during the 60 day ending the days a ween "ADLs [activities of light housekeeping environment." The the patient was taking by mouth] and Q P four hours prn [as not a. The Directory of the propertion of the p	ed consents for treatment on ctor of Nursing failed to care to reflect the correct of 07/31/15 to 09/28/15 and 5.  The medication profile indicated ing failed to include a start profered, potential side effects, on review of the patient / ication reconciliation with the rt of care and failed to do a v of the patient / caregiver  The skilled nursing visit notes, ing failed to complete the esament within the last 5 days pisode.  The for patient #6, SOC wed on 10/13/15 at 12:30 cord included a plan of care sysician with certification of to 10/25/15, with orders for ervices one to four hours per ext for eight week to assist with daily living] and meal prep and to maintain a clean and safe medication profile indicated ing "Ferrous Sulfate 1 daily PO ap 325 mg [milligram] every eeded] for pain."	G 134		
	the plan of care to r periods 08/04/15 to the ADL duties that	eflect the correct certification 10/02/15 and failed to specify the home home health was to nt. The Director of Nursing			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	COM	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C / <b>13/2015</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	1 10	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 134	failed to include the con the Medication probable.  b. The home hed dated 08/04/15, indice was to observe the periodications. The Diservation.  c. The start of considering assessment indicated diet. The plan of carron a regular diet. The plan of was on a low salt diet.  d. The Director plan of carron for care for the control of the co	dosage of the Ferrous Sulfate ofile.  Falth aide written plan of care sated the home health aide atient taking his / her rector of Nursing failed to are to include the medication  are comprehensive defined the patient was on a no salt the indicated the patient was endicated the patient was endicated the patient to the include include include the patient to the include	G 13	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C 0/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u> </u>	0/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 134	a. The failed to update the plan of care trification period of b. The Director plan of care for the c to 12/02/15.  c. Review of the the registered nurse recertification assess during the 60 day ep  d. Review of the the Director of Nursir date and route for all drug regimen review and medication record at the start of care ar regimen review of the recertification.  7. The clinical record on the control of the clinical record in established by a phy of 09/08/15 to to 11/0 Nursing failed to update correct certification.	cluded a plan of care sician for certification period 30/15.  Director of Nursing failed to are to reflect the correct 708/05/15 to 10/03/15.  of Nursing failed to develop a certification period of 10/04/15  e skilled nursing visit notes, failed to complete the sment within the last 5 days isode.  e medication profile indicated and failed to include the start medications, a date for the of the patient / caregiver, inclination with the physician and failed to do a drug are patient / caregiver upon  d for patient #8, SOC are on 10/13/15 at 1:30 PM. Cluded a plan of care sician for certification period 03/15. The Director of ate the plan of care to reflect on period of 09/08/15 to	G 13	34		
	Director of Nursing fa of said medications -	edication profile indicated the ailed to include the purpose oxycontin, amlodipine, orazole, atorvastatin, and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING		C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/10/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	٧
G 134	to include a date for the patient / caregive reconciliation with the care.  8. The clinical record 09/30/15, was review The clinical record in established by a phys of 09/30/15 to 11/26/20 a. The Director of the plan of care to reperiod of 09/30/15 to b. Review of the patient was taking ascorbic acid, aspirin flonase, gabapentin, oxycodone/acetaminerisperdal. The medicate of Nursing famedication section of the medication section of the medication profile.  c. Review of the the Director of Nursin date, potential side eregimen review of the medication reconcilial signed the medication of care.	the listed side effects, failed the drug regimen review of r, and medication a physician at the start of the for patient #9, SOC and on 10/13/15 at 1:43 PM. Cluded a plan of care sician for certification period 15.  If Nursing failed to update alter the correct certification 11/28/15.  If medication profile indicated a galbuterol sulfate, norvasc, low dose, lipitor, nexium, cozar, ophen, miralax, and ation section of the plan of the medication profile. The iled to update the the plan of care to include were listed on the  medication profile indicated a failed to include the start are patient / caregiver, and the profile with date at the start of the profile with date at	G 13			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K131	B. WING		C		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	ı	10/13/2015	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
G 134	b. Previous ex Director of Nursing [intravenous] nurse 2002 to 2014.  c. A skilled nu out by the Director that her assessmer dressing changes], and care], tracheos therapy, ventilation enternal therapy [gare], enema admir removal of fecal impremoval of fecal impremoval of sursections of the second surse	ge 41 or of Nursing resume indicated orked since November, 2014.  Experience indicated that the had been working as an IV for different companies from ersing checklist that was filled of Nursing upon hire indicated of Nursing upon hire indicated on the skills, skin care [example: naso-gastric tubes [insertion tomy care, suctioning, oxygen care, inhalation treatments, astric tube management / nistration, bowel program, paction, and foley catheter er was performed more than	G 13	4			
	indicated that on 06 was read, utilization and demonstrated oproficiency in: Stephealth agency, Hon Administration [who responsibilities of the financial duties, day State and Federal Forganizational and workings of the hor to home care, How CLIA and why your Advance Directives [Limited and when Health Aide registra written test, HIPPA.	os required to open a home					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING		C 10/13/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
G 134	each orientation check box.  e. The bottom horientation check off the Director of Nursin ramifications reviewed comprehension and piles, requires of empregistered nurses, lichome health aides, a policies, agency form Inservices, Employee procedure / requirem column "Able to Utiliz orientation check off indicated the of Nursing read, utiliz reviewed, and demor proficiency in: Blood Certifications for Mediservice, Waiver, TBE can refer patients, W providers can the age and out of state, NPI Face to Face, Indiana home health agencies participation.  The Administrator fai Director of Nursing wassessed, and check failed to ensure that the properly trained in an amount of time, to accomplished.	alf of page two of the indicated that on 06/03/15, ag read, utilization legal and, and demonstrated proficiency in: personnel loyment, Licensure for ensed practical nurses, and therapists, operational as, clinical policies, HIPPA, and manual, Patient admission ents, and forms. The rese Independently" for each thad a line through the box.  If page two of the orientation and the one of the orientation and the office of the orientation and the one of the orientation and the orientation and borne pathogens, dicare, Medicaid, Fee for a funknown meaning, Who that types of medical ency accept orders from in [National Provider Number], and Administrative Codes for s, Federal conditions of	G 13	4	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  B HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	<b>'</b>	10/10/2010
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 134	10/09/15 at 11:45 AN stated that she had resetting for over four yon" nurse during that Nursing indicated she of home health settir infusion companies. Indicated that she had the field and at times 10 patients in one dastated that she was rethe office and that the assist her more with and criminal background 11. The Administrate was interviewed on 11:45 PM. The Admin Director of Nursing does not not be son an as needed base Employee G, the form stepped down to be son an as needed base Employee G or Employee G or Employee G or Stepped to the start of consents were signed.	Nursing was interviewed on M. The Director of Nursing not worked in the office years but has been a "hands at time. The Director of the had not worked in this type in the Director of Nursing in the Administrator has had to hiring, orientation, reference and Director of Nursing in the Administrator has had to hiring, orientation, reference and Director of Nursing in the Administrator of Nursing	G 1	34		
	was hired for the Dire	d was 30 days. The that the Director of Nursing ector of Nursing position seasoned nurse and had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
						С	
		15K131	B. WING_	B. WING		10/	13/2015
	ROVIDER OR SUPPLIER  HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COI 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	DE		
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
G 134	Administrator stated the chart audits.  12. An undated job of Nursing" indicated, "Experience in Home Responsibilities Coodirect and indirect particular personnel policies and procedurecords and quality and for patient charts In home health standar completion and billing discharge charts Ediagnosis, medication	perience. At 2:50 PM, the the Director of Nursing does description titled "Director of	G	134			
G 156	This CONDITION is Based on record revagency failed to ensuraccepted for services would be met for 1 or 157), failed to ensuraccordance to the plane reviewed (See G 158 care was updated to certification periods, providing services to wound treatments, a		G ·	156			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED		
						С	
		15K131	B. WING	B. WING		10/13/2015	
	ROVIDER OR SUPPLIER  HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COD 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
G 156	plan of care in relation her mind of discharger records reviewed (See wound treatments we skilled nurse as orde 2 records reviewed of 165), and failed to were put into writing the date of receipt by 9 records reviewed.  The cumulative effect resulted in the agency with the Condition of Acceptance of Patier Supervision.  484.18 ACCEPTANOMED SUPER  Patients are accepted of a reasonable expect.	ysician of a change in the n to a patient changing his / e of services for 1 of 9 e G 164), failed to ensure ere administered by the red by the physician for 2 of n patients with wounds (See ensure that verbal orders and signed and dated with the registered nurse for 4 of (See G 166).  It of this systemic problem y being out of compliance Participation 484.18 ets, Plan of Care & Medical CE OF PATIENTS, POC,		156			
	medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.  This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure that a patient was accepted for services and that the patient needs would be met for 1 of 9 records reviewed. (#1)  Findings include:  1. Clinical record #1, SOC (start of care) 07/20/15, include a plan of care established by a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COD 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	•	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 157	10/03/15, with order a week for wound cathree hours in the mevening, 7 days a wincluded cerebral value hemiplegia, depress ulcers, and diabetes  a. An entry notedated 06/11/15, indiapatient home expland spouse] we are minimum of staff avakind of guarantee the staff. He / she currefrom another agency employee in this are a part time basis. [Nagreed that anything Explained again aboavailability and states someone in the [Naradmitting her but ouvery limited "  b. An entry notedated 08/17/15, indimultiple calls since a from the owner and of other agency prowhis / her frequent last calling to demand so	ation period of 08/03/15 to a for skilled nursing one time are and home health aide orning and two hours in the eek. Patient diagnoses scular accident [stroke] with ion, lymphadema, stasis  e written in the patient's chart cated "Made a visit to this ained to [Name of patient a new agency and have a sailable. We can't give any at we could provide adequate intly has an aide under waiver or. Told he / she we have one a but she is only available on lame of patient and spouse] is better than nothing but very limited staff of we be attempting to hire me of town] area after a staff availability would be see written in the patient's chart cated "We have received admitting [Name of patient] is scheduling person at [Name of its minute cancellations then of its mediately, his / her g and calling Police, Fire	G	157		
	They have had multi way he / she treats t	ne else he / she can think of. ple aides quit because of the hem. They have given him / ge and will have very limited				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	15K131		B. WING			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COI 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/13/2013	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 157	c. An entry note dated 08/19/15, indic [Name of patient] star not shown up. He / s [urinary tract infection know when to expect know but would chec Director of Nursing, a 1. 8:15 AM and title of spouse] retold him I just texted bresponse." Entry sign Nursing.  2 8:30 AM of still repeating above in had agreed upon time yes they had set up to someone now - instrusomeone but I think to patients I would see it early." Entry signed by a 10 AM [Notalled to inquire if we care for pt [patient]. It be sending someone Director of Nursing.  4. 12 PM S inform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible] & sinform her the pt needs soon as possible]	for him / her until then but  s written in the patient's chart ated "8 AM - Call from tes HHA [home health aide] he is wet - in pain & has UTI n] & impaction - wants to HHA. Told him / her I don't k. Entry signed by the Registered Nurse.  Call from [Name of patient speating same info as above his / her HHA & awaiting ed by the Director of  Call from patient & spouse info - informed per HHA they se of this afternoon - they said he time but they need icted I would try to find hey are all out seeing other if we could get anyone there y the Director of Nursing.  Iame of Fire Department] have anyone going out to informed them yes we would this PM. "Entry signed by  poke with Employee F to dis to be seen ASAP [as he said she would get to she can." Entry signed by	G 1	57			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING_			C 0/13/2015	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		0/13/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 157	Services - questionin out to see pt today - stated he would like on him / her & inform pt currently." Entry s Nursing.  d. An entry noted dated 08/24/15 at 9:2	M Call from Adult Protective ag if we had someone going said yes this PM - caller to have a psych consult done and him of MD's involved with signed by the Director of a written in the patient's chart 24 AM, indicated "Called	G 1	57			
	[Name of pt] to inform to be able to provide current caregivers ur days [name of patien been unable to get a caregivers position. by phone and a lette informing him / her o 11, 2015. We will ma staff [name of patien	n him / her we are not going adequate staffing. His / her navailable for most of the at] needs care and we have n aide to fill the previous. We have informed him / her will go out today 08/24/15 of discharge on September ake all attempts possible to to needs in this 2 week d by the Administrator.					
	dated 08/31/15 at 12 physician had called enema to be given. registered nurse to a The entry was signed.  f. An entry note dated 09/01/15 at 10 multiple calls to [nam a letter stating we are due to the fact our 'a of 09/07 the patient hiphone calls accusing abandonment. We hattempted to find a result of 19/10 at 19/1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CAR	EINC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 157	number of last minustaff to leave after the calls a few housed someone immediate fire department and produce an aide. If agency [name of age discharging him / he stated he /she had employees. Dr. Mill and is seeking payout the Administrator.  In agency [name of age discharging him / he stated he /she had employees. Dr. Mill and is seeking payout the Administrator.  In a entry no dated 09/03/15 at 1 arriving at their hom inside saying she would not help him / her and verified with the pat wanted and then lean order from her down of the lean order from her down	ave a difficult time with the ste cancellations and telling hey get there and then he / rs later demanding we send ely and calls the police, the APS when we are unable to received a call from the other sency] telling me they are er for the same reason. They caused them to loose 8 ler is aware of the problem the consult." Entry signed by the written in the patient's chart 0:20 AM, indicated " Upon the the patient refused to go as impacted and that i could and asked me to leave. I dient that was what he / she fit. The patient had received foctor for a fleets enema on the patient refused due to the experience of the administer the experience of the patient refused to let me and the services who had been the stered Nurse who had been the health aide missed visit	G 1	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C 1 <b>0/13/2015</b>
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10,10,2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 157	b. Missed visit indicated, "After dec / her hours at one vispatient] called comp second visit. Explair on admission we haw would come that far else available" EAdministrator.  c. Missed visit indicated, "[Name of and was informed th [evening] vst [visit] Administrator.  d. Missed visit indicated, "His / her refusing replacement another agency and	report dated 08/04/15 iding with HHA to have all his sit rather than split [Name of laining and demanding a ned as he / she had been told divery limited people who north and there was no one Entry entered by  report dated 08/05/15 patient] answered phone ere is no one for eve " Entry entered by  report dated 08/10/15 HHA is on vacation and pt is t. He / she has an aide from skilled nurse will try to fill in	G	57		
	e. Missed visit indicated, "Skilled no basic care with skille as aide is on vacation north. Family is awa agency was there." Administrator.  f. Missed visit r "Skilled nurse there but the aide from an	eport dated 08/13/15 indicate, for visit. We have no aide other agency is there. Pt call t] to transfer her." Entry				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED			
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 157	indicated, "Skilled nu from DPM [podiatrist group]. No aide from Ages Home Health C care for one visit. No entered by Administration.  h. Missed visit indates of 08/15/15 to informed again that in DPM [Name of Physicompression dressin Group] so no skilled entered by Administration.  i. Missed visit reindicated, "Patient of visit on her caregiver visit and then called and demand an even no one to come this Administrator.  j. Missed visit reindicated, "After settiaide to come as bein complain about no ocal the fire dept and neglected. Aide was patient for PM visit Administrator.  k. Missed visit reindicated, "Patient agon 08/18 to be at her then called on 08/19 someone come to her	report dated 08/14/15 rise visit and pt has vst [visit] rise rise rise rise rise rise rise rise	G 1	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	15K131	B. WING _			C <b>10/13/2015</b>	
	INC		STREET ADDRESS, CITY, STATE, ZIP COL 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	DE	10/13/2013	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
7 Continued From page 52 had set a scheduled PM visit " Entry entered by		G <sup>2</sup>	157			
I. Missed visit re indicated, "Called [Na we have no one to m 08/23/15. Discussed who is going to tell [Na she is not available 0 Administrator.  m. Missed visit indicated, "No one av [Spouse] will do his / office had informed p there would no no AN called complaining an any one they could cabandonment." Entromalizated, "Called [Na to let them know thei available for a PM visit told his / her the care job on 09/06 and we time. He / she should agency." Entry enter o. Missed visit redates 08/25/15 PM a "Patient had been inf 08/24/15 that there we the PM visit on 08/25 Administrator.  p. Missed visit redates of the property of the pr	apport dated 08/21/15 ame of patient] to inform her ake her AM visit on this also with her caregiver lame of patient and spouse] 8/23." Entry entered by  report dated 08/24/15 vailable for AM visit. her care. HHA and the t and [spouse] on 08/21 M visit on 08/23 yet they nd threatening to report us to all accusing us of y entered by Administrator.  report dated 08/24/15 ame of patient and spouse] r caregiver will not be sit on 08/25 and 08/27. Also giver is leaving for another have no replacement at this d look for an alternate ed by Administrator.  report dated 08/25/15 for visit and 08/27/15 PM, indicated ormed in advance on rould be no one available for & 08/27." Entry entered by					
indicated, "Patient ha	d been notified no one					
	ROVIDER OR SUPPLIER  SHOME HEALTH CARE  SUMMARY ST (EACH DEFICIENC REGULATORY OR I  Continued From page had set a scheduled Administrator.  I. Missed visit re indicated, "Called [Na we have no one to m 08/23/15. Discussed who is going to tell [N she is not available 0 Administrator.  m. Missed visit re indicated, "No one av [Spouse] will do his / office had informed p there would no no AN called complaining ar any one they could ca abandonment." Entry  n. Missed visit re indicated, "Called [Na to let them know their available for a PM vis told his / her the care job on 09/06 and we time. He / she should agency." Entry enter  o. Missed visit re dates 08/25/15 PM a "Patient had been inf 08/24/15 that there w the PM visit on 08/25 Administrator.  p. Missed visit re indicated, "Patient had	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 52 had set a scheduled PM visit." Entry entered by Administrator.  I. Missed visit report dated 08/21/15 indicated, "Called [Name of patient] to inform her we have no one to make her AM visit on 08/23/15. Discussed this also with her caregiver who is going to tell [Name of patient and spouse] she is not available 08/23." Entry entered by Administrator.  m. Missed visit report dated 08/24/15 indicated, "No one available for AM visit. [Spouse] will do his / her care. HHA and the office had informed pt and [spouse] on 08/21 there would no no AM visit on 08/23 yet they called complaining and threatening to report us to any one they could call accusing us of abandonment." Entry entered by Administrator.  n. Missed visit report dated 08/24/15 indicated, "Called [Name of patient and spouse] to let them know their caregiver will not be available for a PM visit on 08/25 and 08/27. Also told his / her the caregiver is leaving for another job on 09/06 and we have no replacement at this time. He / she should look for an alternate agency." Entry entered by Administrator.  o. Missed visit report dated 08/25/15 for visit dates 08/25/15 PM and 08/27/15 PM, indicated "Patient had been informed in advance on 08/24/15 that there would be no one available for the PM visit on 08/25 & 08/27." Entry entered by	TOWNIDER OR SUPPLIER  SHOME HEALTH CARE INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 52  had set a scheduled PM visit." Entry entered by Administrator.  I. Missed visit report dated 08/21/15 indicated, "Called [Name of patient] to inform her we have no one to make her AM visit on 08/23/15. Discussed this also with her caregiver who is going to tell [Name of patient and spouse] she is not available 08/23." Entry entered by Administrator.  m. Missed visit report dated 08/24/15 indicated, "No one available for AM visit. [Spouse] will do his / her care. HHA and the office had informed pt and [spouse] on 08/21 there would no no AM visit on 08/23 yet they called complaining and threatening to report us to any one they could call accusing us of abandonment." Entry entered by Administrator.  n. Missed visit report dated 08/24/15 indicated, "Called [Name of patient and spouse] to let them know their caregiver will not be available for a PM visit on 08/25 and 08/27. Also told his / her the caregiver is leaving for another job on 09/06 and we have no replacement at this time. He / she should look for an alternate agency." Entry entered by Administrator.  o. Missed visit report dated 08/25/15 for visit dates 08/25/15 PM and 08/27/15 PM, indicated "Patient had been informed in advance on 08/24/15 that there would be no one available for the PM visit on 08/25 & 08/27." Entry entered by Administrator.  p. Missed visit report dated 08/27/15 indicated, "Patient had been notified no one	TORNECTION  15K131  ROVIDER OR SUPPLIER  SHOME HEALTH CARE INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 52 had set a scheduled PM visit." Entry entered by Administrator.  I. Missed visit report dated 08/21/15 indicated, "No one available for AM visit. [Spouse] will do his / her care. HHA and the office had informed pt and [spouse] on 08/24 indicated, "Called [Name of patient and spouse] to let them know their caregiver will not be available for AM visit.  Spouse] will do his / her care. HHA and the office had informed pt and [spouse] on 08/21 there would no no AM visit on 08/23 yet they called complaining and threatening to report us to any one they could call accusing us of abandonment." Entry entered by Administrator.  n. Missed visit report dated 08/24/15 indicated, "Called [Name of patient and spouse] to let them know their caregiver will not be available for a PM visit on 08/25 and 08/27. Also told his / her the caregiver is leaving for another job on 09/06 and we have no replacement at this time. He / she should look for an alternate agency." Entry entered by Administrator.  o. Missed visit report dated 08/25/15 for visit dates 08/25/15 PM and 08/27/15 PM, indicated "Patient had been informed in advance on 08/24/15 indicated," Patient had been notified no one	TOURIDER OR SUPPLIER  SHOME HEALTH CARE INC  SUMMARY STATEMON OF DEPICIENCES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 52 And set a scheduled PM visit." Entry entered by Administrator.  I. Missed visit report dated 08/21/15 indicated, "Called [Name of patient] to inform her we have no one to make her AM visit on 08/23/15. Discussed this also with her caregiver who is going to tell [Name of patient] to inform her we have no one to make her AM visit. (Spouse) will do his / her care. HHA and the office had informed pt and [spouse] on 08/21 there would no no AM visit on 08/23 yet they called complaining and threatening to report us to any one they could call accusing us of abandonment." Entry entered by Administrator.  n. Missed visit report dated 08/24/15 indicated, "Called [Name of patient and spouse] to let them know their caregiver will not be available for a PM visit on 08/23 and 08/27. Also told his / her the caregiver is leaving for another job on 09/06 and we have no replacement at this time. He / she should look for an alternate agency." Entry entered by Administrator.  o. Missed visit report dated 08/25/15 for visit dates 08/25/15 PM and 08/27/15 PM, indicated "Patient had been informed in advance on 08/24/15 his there would be no one available for the PM wisit on 08/25 & 08/27." Entry entered by Administrator.  p. Missed visit report dated 08/27/15 indicated, "Patient had been notified no one	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING_		1	C <b>0/13/2015</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		0/13/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 157	date 08/30/15 indica no one is available for We have called all strain drive that far north."  Administrator.  r. Missed visit ro 08/30/15 indicated, "on 08/28 there would AM visit this day." Established in the strain dicated, "Patient had and letter that this canother job and we had after advertising visit today." Entry e	report dated 08/28/15 for visit ted, "Called patient to tell her or her AM visit on 08/30/15. aff members and no one will Entry entered by  report dated 08/31/15 for visit Patient had been informed to be no one available for the ntry entered by Administrator.  report dated 09/01/15 report dated 09/01/15 regiver is leaving to take nave been unable to hire an and interviewing. No PM retered by Administrator.  report dated 09/07/15 report dated 09/07/07/07/07/07/07/07/07/07/07/07/07/07/	G 1	57			
	3. The Administrator 10/08/15 at 2:50 PM	was interviewed on The Administrator stated					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	I	10/13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 157	prior to admission of being a new compathat the patient had home health aide, of and then would war The Administrator is take the patient due been fired by the patha. The Director of No. 10/09/15 at 11:15 A stated the patient wagency had two hor care for the patient aides found out who declined to work for Nursing stated that registered nurse an provide care to the when she can and Registered Nurse a Nursing, agreed to Manager. The Dire was not able to assenema on 09/03/15 other patient's and town.  5. An undated polic Process indicated, initiated until an init completed and ider by the agency. The needs can be met to determine whether for services are appropriate to the physical, psysical, psysic	spouse had been informed of their staffing issues and any. The Administrator stated refused multiple visits from constantly change the hours assistance without notice. tated she was "begged" to be to multiple agencies had	G 18	57			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COL 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 157	Instructions: Admiss which a client can be admission. These st home environment is proper home care. d. safely and adequatel includes the ongoing equipment and a plat emergencies. e. Ho the client's place of regeographic area served Agency is capable of or service at the leve condition requires must conform with compactice for the result of practice for the result of a medicanot admit client or compact the following situation of needs cannot be not suitability of agency promeet client needs. It caregiver support such agency cannot furneed, a referral will be community resources notified "  484.18 ACCEPTANOMED SUPER  Care follows a writter	rovide services. Special ion Criteria are standards by deemed appropriate for andards include c. The suitable or adaptable for The client's needs can y be met at home. This availability of personnel and into meet medical me care services provided in esidence are within the red by the agency. f. The providing the needed care of intensity the client's j. The services and care intent professional standards expective discipline and eand necessary to the all disorder 2. Agency will intinue to provide services in ins. a. Scope and complexity net by agency. b. Skills and personnel are not adequate c. The client's life situation yetem does not provide for a and supervision 13. If lifill the required health care is made to other appropriate is and referral source will be see OF PATIENTS, POC,	G 15			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY OMPLETED			
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		16/16/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 158	Continued From page This STANDARD is Based on record recagency failed to ensite treatment and mana accordance to the plant reviewed. (#1, 3, 5, Findings include:  1. Clinical record #1 07/20/15, include a physician for certification 10/03/15, with orders a week for wound cathree hours in the mevening, 7 days a wincluded cerebral valued hemiplegia, depressulcers, and diabetes to apply non-adhere kerlix or similar prodreapply and evaluated.  a. Review of thindicated there were between 07/20/15 to	not met as evidenced by: view and interview, the ure visits were made, wound gement was followed in an of care for 4 of 9 records 7)  , SOC (start of care) blan of care established by a ation period of 08/03/15 to a for skilled nursing one time are and home health aide orning and two hours in the eek. Patient diagnoses scular accident [stroke] with ion, lymphadema, stasis . Treatment orders indicated int dressing and secure with uct. Teach husband to e wound progress weekly. e skilled nursing notes no skilled nursing visits 108/03/15, the skilled nurse	G 1	DEFICIENCY)		
	visits during week two visits during week for nurse failed to follow 1. Skilled r 08/05/15, indicated to back from the physic was being developed include treatment pro-	during week one, two extra vo, and no skilled nursing ur, five, and six. The skilled verthe plan of care.  The plan of care dated he nurse was waiting a call cian and that a treatment plan d. The visit note failed to evided during the visit and educated on management of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 158	Continued From pag	e 57	G 1	58		
	08/12/15, indicated the with a waterproof not skilled nurse failed to order and failed to inteducated on the man and skilled round after apply dressing) and failed educated on the man and skilled round after apply dressing) and failed educated on the man and skilled round after apply dressing) and failed educated on the man b. Review of the notes indicated there visits between 07/20 were missed on 08/00/16, 08/17, 08/19, 09/08, 09/09, 09/10, were missed on 08/00/08/22 (only 1 hour proposition of the notes indicated there visits between 07/20 were missed on 08/00/08/16, 08/17, 08/19, 09/08, 09/09, 09/10, and 08/22 (only 1 hour proposition of the notes indicated in one visity physical poly on the skilled proposition of the skilled proposition	, SOC 11/13/14, included a ned by a physician for f 05/14/15 to 07/13/15, with				
	certification period or orders for skilled nur	f 05/14/15 to 07/13/15, with sing one time a week for 9 n set up, homemaker one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		15K131	B. WING		10/13/2015
	ROVIDER OR SUPPLIER	EINC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
G 158	Continued From pag	ge 58	G 15	8	
	skilled nurse failed t between during wee b. Review of th	e skilled nursing notes, the o make a nursing visit ek one.  e home maker visit notes, the o make a visit duirng week			
	plan of care establis certification period of with orders for skille month for two month compliance, safety,	5, SOC 07/31/15, included a hed by a physician for of 07/31/15 to to 09/10/15, d nursing two to three times a to assess, medication home health aide patient's overall health and			
	day, three to five da personal care to inco or shower, shampool light housekeeping to safe environment. F	ervices three to four hours a ys a week to assist with lude partial to complete bath b, skin care, meal preparation, to help maintain clean and Review of the skilled nursing ence skilled nursing visits			
	10/13/15 at 12:00 P 09/03/15, indicated visits three to five ho days per week. PT function based on the balance problems werequire therapy. We stand without assist PT to develop progration follow "Review of notes on 10/13/15 a were no home healt	record was reviewed on M. A physician order dated "HHA [home health aide] burs per day, three to five [Physical therapy] to restore he following clinical findings, with household transfers, heakness limiting ability to heakness limiting ability to heakness trength training. heam home health aide can hof the home health aide visit t 12:00 PM, indicated there heade visits between health aide to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED			
		15K131	B. WING			C / <b>13/2015</b>
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u> </u>	13/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 158	b. A physician of indicated to "decrease one hour per day, see approval. Increase visecondary to family wavailable at this time. aid visits notes, indicated started seeing the on 09/13/15. The hor follow the plan of care.  c. An interview violation to the care of the ca	rder dated 09/17/15, e home health aide visits to condary to Medicaid sits to seven days per week veekend coverage not. Review of the home health ated that the home health ated that the home health apatient for one hour per day me health aide failed to e.  with the Administrator on II, stated that the patient did I after the medicaid prior proved.  SOC 08/05/15, included a ed by a physician for 08/05/15 to to 09/30/15, nursing one to four times in set up and assessment. Including notes, failed to ng visits 08/05/15 to SOC 09/30/15, included a ed by a physician for 09/30/15 to 11/26/15, with sing one time a week for e health aide services three three to five days a week for	G 15	8		
	indicated that the skil	skilled nursing visit notes led nurse made an extra . The skilled nurse failed to				

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C 10/13/2015		
	ROVIDER OR SUPPLIER	NC		1	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	1 10/	13/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 158	indicated that the hon services until week tw health aide failed to fo 6. The Administrator 10/13/15 at 3:50 PM, any further document regarding the findings 7. An undated policy indicated, "Provides of management for a tea	home health aide visit notes ne health aide did not start vo on 10/06/15. The home ollow the plan of care.  was interviewed on and was unable to provide ation and / or information a referenced above.	G	158				
G 159	The plan of care dever the agency staff cove including mental statu equipment required, f prognosis, rehabilitati limitations, activities prequirements, medica safety measures to prognosis for timely any other appropriate.  This STANDARD is represented the state of	eloped in consultation with rs all pertinent diagnoses, us, types of services and requency of visits, on potential, functional permitted, nutritional utions and treatments, any rotect against injury, discharge or referral, and items.	G	159				

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING		C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION	
G 159	2, 4, 5, 6, 7, 8, and Findings include:  1. The clinical reco on 10/08/15. The c of care established care date of 08/03/1 08/03/15 to 10/03/1 nursing one time a v treatment ordered of for the skilled nurse dressing and secure  a. Review of the the patient had sign 07/20/15. The plan to reflect the correct and a certification p The plan of care als	ard of patient #1 was reviewed linical record included a plan by a physician for a start of 15 with a certification period of 5, with orders for skilled week for wound care. The in the plan of care indicated to apply non-adherent with kerlix or similar product.  The service agreement indicated ed consents for treatment on of care failed to be updated a start of care date of 07/20/15 eriod of 07/20/15 to 09/17/15. To failed to include the location and, how to clean the wound,	G 15	9		
	assessment dated ( Plan of Care Synop ordered plan of care Diabetic foot care in presence of skin les and patient / caregio care - yes, c. Falls d. Depression inter referral for other tre or current treatment that patient screene yes, e. Intervention - yes, f. Intervention	tart of care comprehensive 08/03/15, indicated "M2250 sis Does the physician - e include the following b. including monitoring for the sions on the lower extremities wer education on proper foot prevention interventions - yes, ventions such as medication, atment, or a monitoring plan and / or physician notified and positive for depression - s to monitor and mitigate pain as to prevent pressure ulcers - of care failed to be updated to				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		ATE SURVEY OMPLETED	
		15K131	B. WING			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 159	indicated "see attact plan of care failed to the medication profiprescribed.  2. The clinical record o7/29/15, was revied The clinical record in established by a phy 07/29/15 to 09/05/15 with orders for home assistance with personal medication reminder maintain a safe and  a. The plan of reflect the correct of 09/26/15 and 09/27/15 b. The agency and duration of home that the type of personal were to provide for the correct patient #4 was obseright and left trochair	ion portion of the plan of care ned medication profile." The pinclude medications listed on the that the patient was taking / and of patient #2, SOC wed on 10/08/15 at 3:45 PM. Included two plans of care visician for certification period and 09/05/15 to 10/31/15, we health aide visits for sonal care, meal preparation, or and light house keeping to clean environment.	G 18				
	weeks prior, for a ur patient stated he / s antibiotics in August antibiotics from the medication profile lis	nd again approximately two inary tract infection. The he was discharged with oral but was not discharged with recent hospital stay. The sted on both of the plans of atient was taking Clindamycin					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  B HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	'	10/10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 159	08/04/15, was review The clinical record in established by a phy date of 08/06/15 and 08/06/15 to 09/25/15 with orders for skilled dressing changes to pubic catheter change 1. The corr 08/04/15 to 10/02/15 The Registered Nurs	ecord for patient #4, SOC wed on 10/09/15 at 1:30 PM. cluded a plan of care sician with a start of care certification periods and 09/26/15 to 11/07/15 d nursing daily for wet to dry "decubes both hips," supra yes monthly.	G 1	59		
	2. Review comprehensive assedumented wounds an area to the right heel. The treatment dressings to "both hi comprehensive asseindicated to clean the cleanser, pack with kapply ABD, then secdressing. The Registhe plan of care to relocation of wounds the treatment provided to frequency of dressing preformed.	ps." A resumption of care ssment dated 09/03/15, e wounds with wound cerlix soaked normal saline, ure with a transparent tered Nurse failed to update flect the accuracy of the nat was being treated, the peach wound, and the g changes that were to be				
	the current plan of ca	pistered Nurse failed to update are medication profile section offics, to include interventions ary tract infections, and to bulb inflation of the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	· ,	TE SURVEY MPLETED	
		15K131	B. WING		1	C 0/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		10/13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
G 159	The clinical record in established by a physof 07/31/15 to to 09/31/105/15. The plan or reflect the correct cert to 09/28/15 and 09/25. The clinical record 08/04/15, was review The clinical record in established by a physoeriods of 08/04/15 home health aide ser day five days a week "ADLs [activities of d light housekeeping to environment." The native patient was taking [by mouth] and Q Parafour hours prn [as new a. The plan of correflect the correct cert 10/02/15 and failed to the home home health patient. The Medical the dosage of the Ferbal b. The home hed dated 08/04/15, indicated to observe the product of the plan of the plan of the plan of the dosage of the Ferbal b. The home hed dated 08/04/15, indicated to observe the productions. The plan of th	d for patient #5, SOC red on 10/13/15 at 12:00 PM. cluded a plan of care sician for certification period 10/15 and 09/10/15 to of care failed to be updated to rtification period of 07/31/15 9/15 to 11/27/15.  d for patient #6, SOC red on 10/13/15 at 12:30 PM. cluded a plan of care sician with certification to 10/25/15, with orders for rvices one to four hours per for eight week to assist with ally living] and meal prep and of maintain a clean and safe nedication profile indicated of "Ferrous Sulfate 1 daily PO p 325 mg [milligram] every eded] for pain."  are failed to be updated to rtification periods 08/04/15 to of specify the ADL duties that th was to provide to the clion Profile failed to include rrous Sulfate.  alth aide written plan of care ated the home health aide	G 1	59			

	DF DEFICIENCIES CORRECTION	(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K131	B. WING	B. WING		C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	INC		1	STREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	107	13/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 159	diet. The plan of care on a regular diet. The updated to include the diet.  d. The clinical record updated plan of care 10/03/15 to 12/01/15.  6. The clinical record 08/05/15, was review The clinical record incestablished by a physof 08/05/15 to to 09/3  a. The plan of care to 10/03/15.  b. The clinical record to 10/03/15.  b. The clinical record 10/04/15 to 12/02/15.  7. The clinical record 09/08/15, was review The clinical record incestablished by a physof 09/08/15 to to 11/0 to be updated to refleperiod of 09/08/15 to 8. The clinical record incestablished by a physof 09/30/15, was review The clinical record incestablished by a physof 09/30/15, to 11/26/10/15/15/15/15/15/15/15/15/15/15/15/15/15/	If the patient was on a no salt indicated the patient was end plan of care failed to be end patient was on a low salt end for certification periods of a for patient #7, SOC end on 10/13/15 at 1:00 PM. Cluded a plan of care sician for certification period 0/15.  Faire failed to be updated to trification period of 08/05/15 end failed to include an for certification periods of a for patient #8, SOC end on 10/13/15 at 1:30 PM. Cluded a plan of care sician for certification periods of a for patient #8, SOC end on 10/13/15 at 1:30 PM. Cluded a plan of care failed ct the correct certification period 3/15. The plan of care failed ct the correct certification 11/06/15.  If or patient #9, SOC end on 10/13/15 at 1:43 PM.	G	159			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			C 10/13/2015
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<b>,</b>	10/10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 159	Continued From page	e 66	G 18	59		
	-	are failed to be updated to tification period of 09/30/15				
	the patient was taking ascorbic acid, aspirin flonase, gabapentin, oxycodone/acetamino risperdal. The plan o					
	interviewed on 10/09/ of Nursing stated that certification period wa Administrator and Dir	as 30 days. The ector of Nursing had nothing rds to the start of care being				
	indicated, " The ph	y titled "Medical Supervision" ysician orders shall outline ing care and the type, on of services to be				
	indicated, " All orde	y titled, "Physician Orders" ers for medications must he drug, dosage, route of irections of use "				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K131		B. WING		C 10/13/2015	
	ROVIDER OR SUPPLIER	INC		1	STREET ADDRESS, CITY, STATE, ZIP CODE 081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 164 G 164	CARE Agency professional	REVIEW OF PLAN OF staff promptly alert the ages that suggest a need to		164 164			
	Based on record revi agency failed to notify in the plan of care in	not met as evidenced by: iew and interview, the the physician of a change relation to a patient changing narge of services for 1 of 9					
	Clinical record #2, plan of care establish certification period 09     a. A physician of	n/05/15 to 10/31/15.  Inder dated 09/24/15,  Inder patient] from all					
	indicated that a home the patient on 09/30/1						
	12:40 PM, stated the discharged from serv agency failed to notify patient had changed	ry note dated 10/02/15 at patient wanted to be ices immediately. The y the physician that the his / her mind about services 1/15 and stopping again on					
	2. The Administrator 10/08/15 at 3:45 PM.	was interviewed on The Administrator stated					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	
						(	
		15K131	B. WING _			10/	13/2015
	ROVIDER OR SUPPLIER  HOME HEALTH CARE I	NC		10	TREET ADDRESS, CITY, STATE, ZIP CODE  181 THIRD AVENUE, SW, SUITE # 5  ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 164	discharge order was not seen as a seed of the following of client condition or age compliance of the clicare "  484.18(c) CONFORM ORDERS	to be discharged on nged his mind and the not canceled.  titled "Medical Supervision" an will be contacted when occurs e. Any change in ency services, including non ient related to the plan of		164			
	This STANDARD is r Based on observation interview, the agency treatments were admit as ordered by the phy reviewed on patients.  Findings include:  1. Clinical record #1, 07/20/15, include a pl physician for certificat 10/03/15, with orders a week for wound car included cerebral vas hemiplegia, depression ulcers, and diabetes. to apply non-adheren kerlix or similar produ	not met as evidenced by: n, record review and failed to ensure wound inistered by the skilled nurse visician for 2 of 2 records with wounds. (#1 and 2)  SOC (start of care) an of care established by a tion period of 08/03/15 to for skilled nursing one time e. Patient diagnoses cular accident [stroke] with on, lymphadema, stasis Treatment orders indicated t dressing and secure with					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF  A. BUILDING (X3) DATE SUF		OMPLETED	
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/13/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 165	waterproof non-adhes skilled nurse failed to order.  b. Skilled nursing indicated the nurse of wound to the 2nd took identified on 08/05/1 obtain an order for the wound on the left food.  Clinical record #4 plan of care establish start of care date of the periods 08/06/15 to 011/07/15 with orders wet to dry dressing of hips."  a. During a hom AM, the Director of Neperform a dressing of the left trochanter and and left trochanter, left.	dressed the wound with a sive edge gauze. The ofollow the current treatment and visit note dated 08/13/15, shanged a Band-Aid to a e on the left foot that was 5. The skilled nurse failed to eatment of the 2nd toe	G ^	/		
	q-tips and wound clewith 4 x 4 gauze, spr three times to an ant traditional kerlix, as i firmly packed the righ buttocks wound, app wound between the covered all wounds with the dressings with hy Nursing was also ob- with wound cleanser secured with cover re-	anser, wiped the wounds rayed wound cleanser two to imicrobial kerlix vs the nstructed by the patient, and nt / left trochanter and left lied the same kerlix to the reft buttocks and trochanter, with ABD pads, and secured rdrofilm. The Director of served to clean the left heal applied a dry dressing and bil. During the observation, ng confirmed with the patient				

NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC  (X4) ID PREFIX TAG  TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (B 165  Continued From page 70  of the treatments being done by Employee H, a Registered Nurse, who routinely sees the patient. The patient had a large box of antimicrobial kerlix  STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032  ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O THE PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC  (X4) ID PREFIX TAG  TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (B 165  Continued From page 70  of the treatments being done by Employee H, a Registered Nurse, who routinely sees the patient. The patient had a large box of antimicrobial kerlix  STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032  ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O THE PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	C 10/13/2015	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	2013	
of the treatments being done by Employee H, a Registered Nurse, who routinely sees the patient. The patient had a large box of antimicrobial kerlix	(X5) OMPLETION DATE	
in his bedroom.  b. The clinical record was reviewed on 10/09/15 at 1:30 PM. The skilled nursing visit note dated 10/03/15, indicated Employee H observed the patient to have a new wound between the left buttocks and left trochanter. The description provided indicated the wound had slough but no drainage. A skilled nursing notes dated 10/04, 10/05, 10/06, 10/07, and 10/08/15, indicated Employee H provided wound treatment by cleansing the wound with wound cleanser, then applying normal saline wet to dry dressing and secured with cover-roll.  c. Skilled nursing visit notes from 08/06/15 to 08/29/15, 09/03/15 to 09/18/15, and 09/26/15 to 10/09/15, indicated the right / left trochanter and left buttock wounds were being cleaned with wound cleanser, wounds being pack with normal saline wet kerlix, then 4 x 4, ABD padding, and secured with hydrofilm transparent dressing. The left heel was being cleansed with wound cleanser, 4 x 4 normal saline wet to dry, and coverall to secure.  The Director of Nursing and Employee H was providing specific wound treatments, such as wound cleanser, antimicrobial kerlix, ABD, and hydrofilm to the right / left trochanter and left buttocks without a physician's order. The Director of Nursing and Employee H was providing wound treatments to the new pressure area between the left trochanter and buttock as		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K131	B. WING				C 13/2015
	ROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  ARMEL, IN 46032	10/	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 165	further documentation regarding the findings exit conference on 10 4. An undated policy indicated, "All medica	was unable to provide any and / or information referenced above by the //13/15 at 3:50 PM.	G	165			
G 166	physician. 484.18(c) CONFORM ORDERS  Verbal orders are put dated with the date of nurse or qualified the	in writing and signed and receipt by the registered rapist (as defined in section responsible for furnishing or	G	166			
	Based on record revi ensure that verbal ord and signed and dated	not met as evidenced by: ew, the agency failed to ders were put into writing I with the date of receipt by or 4 of 9 records reviewed.					
	1. Clinical record #1, 07/20/15. A skilled no 08/14/15, indicated "v [dressings] & wd [woo cont [continue] termin HHC [Home Health C higher level of care if	ursing visit note dated vrap profore drsngs und] care by their provider - tate wound care by All Ages are], Inc. Discharge to unable to safely be cared lymphadema by [Name of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 166	- Communication page 1		G 1	66		
	signature and date o	put the order in writing with freceipt.				
	plan of care establish	, SOC 11/13/14, included a ned by a physician for f 05/14/15 to 07/13/15.				
	a. Review of the skilled nursing visit notes, the last skilled nursing visit note was 06/11/15.					
	to discharge the pati The agency failed to	eview of the physician orders, an order rge the patient was written on 06/29/15. It is given by the patient was written or order to be within a timely manner.				
	note written by the A indicated Employee report that the patier and was resuming the left heel as ordered.	, SOC 08/04/15. An entry dministrator on 09/04/15, H had notified the office to at heel decube had reopened se wet to dry dressings to the Employee H failed to put the signature and date of receipt.				
	plan of care establist certification period of orders for skilled nur nine weeks to evaluate for healing and possevaluate ulcer on rig	, SOC 09/30/15, included a ned by the physician for the f 09/30/15 to 11/26/15, with sing one time a week for ate left below the knee stump lible skin breakdown and ht "bk" [below the knee] for any or non healing and				
	10/02/15, indicated t wound treatment to t cleansing the area w	e skilled nursing note dated he skilled nurse provided he right, second toe by ith wound cleanser, applying applied a dressing and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		15K131	B. WING _			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COD 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	DE	10/13/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 166	nursing note failed to contacted for treatments.  b. A fax and a properties of the contacted for treatments.  b. A fax and a properties of the contacted for treatments. The Direct document the correct location of the wound accurate frequency of the contact of t	g by aseptic technique. The principal indicate if the physician was ent orders.  Ohysician's order dated wed in the front pocket of the ecomment section of the fax at has open area rt [right] and neosporin ointment over ls there anything else you? The physician order ply neosporin oint [ointment] toe prn [as needed]." The the Director of Nursing but atte of accepting the order.  Se skilled nursing note dated the skilled nurse provided the right, second toe by with wound cleanser, applying applied a dressing and g by aseptic technique.  If to obtain a verbal order rior to performing any wound cor of Nursing failed to et ointment, provide the right d, and failed to provide an of wound care that the	G	166			
	that orders located in record were orders t from the physician. able to state if Emplo	. The Administrator stated in the front of the patient's hat were waiting for signature The Administrator was not byee H or the Director of d verbal orders prior to atment.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		15K131	B. WING			10/	13/2015
	ROVIDER OR SUPPLIER  HOME HEALTH CARE	NC		108	REET ADDRESS, CITY, STATE, ZIP CODE B1 THIRD AVENUE, SW, SUITE # 5 ARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 166	Continued From page	274	G	166			
G 168	indicated, "All medical services provided to complysician. The orders telephone or in writing countersigned by the manner 1 The the date, specific orders.	clients must be ordered by a s may be initiated via g and must be physician in a timely verbal order must include er, be signed with the full person receiving the order sysician for signature.	G	168			
	Based on record revi Registered Nurse faile made and wound trea was followed in accor for 5 of 9 records revi failed to ensure the pi reflect the correct cer disciplines providing s changes in wound tre discontinued medicat reviewed (See G 173 and knowledgable in and assessment for 1 and failed to complete patient patient's wour	ew and interview, the ed to ensure visits were atment and management dance to the plan of care ewed (See G 170), Nurse an of care was updated to tification periods, duties of services to the patient, atments, and current and ions for 6 out of 9 records ), and failed to be prepared providing wound treatment of 1 home visits observed ely assess and document a lad for 2 of 3 records with wound treatments (See					
	resulted in the agency	of this systemic problem y being out of compliance Participation 484.30 Nursing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING		1	C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	NC		STREET ADDRESS, CITY, STATE, ZIP COL 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		0/13/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 168	Continued From page Service.	÷ 75	G 16	68			
G 170	484.30 SKILLED NUI	RSING SERVICES	G 17	70			
	The HHA furnishes sl accordance with the p	cilled nursing services in plan of care.					
	Based on record rev Registered Nurse fail made and wound trea was followed in accor	not met as evidenced by: ew and interview, the ed to ensure visits were atment and management dance to the plan of care ewed. (#1, 3, 5, 7, and 9)					
	Findings include:						
	physician for certifica 10/03/15, with orders a week for wound car included cerebral vas hemiplegia, depression ulcers, and diabetes. to apply non-adherent kerlix or similar produ	an of care established by a tion period of 08/03/15 to for skilled nursing one time					
	indicated there were between 07/20/15 to made one extra visit visits during week two	skilled nursing notes no skilled nursing visits 08/03/15, the skilled nurse during week one, two extra o, and no skilled nursing ur, five, and six. The skilled the plan of care.					
		ursing visit note dated e nurse was waiting a call					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		15K131	15K131 B. WING		C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE COMPLETION
G 170	was being developed include treatment proteinclude treatment proteinclude treatment proteinclude treatment proteinclude treatment proteinclude to say the wound.  2. Skilled n 08/12/15, indicated the with a waterproof nor skilled nurse failed to order and failed to include a skilled on the mar.  3. Skilled n 08/13/15, failed to include the wound after apply dressing) and failed the educated on the mar.  4. Skilled n 08/14/15, failed to include the say	ian and that a treatment plan I. The visit note failed to ovided during the visit and educated on management of  ursing visit note dated ne nurse dressed the wound n-adhesive edge gauze. The ofollow the current treatment dicate if the spouse was lagement of the wound.  ursing visit note dated dicate if kerlix was applied to oving telfa (non adhering no indicate if the spouse was lagement of the wound.  ursing visit note dated dicate if the spouse was lagement of the wound.	G 17	70	
	2. Clinical record #3 plan of care establish certification period of orders for skilled nurs weeks for medication skilled nursing notes make a nursing visit  3. Clinical record #5 plan of care establish certification period of with orders for skilled month for two month compliance, safety, h	asgement of the wound.  SOC 11/13/14, included a need by a physician for 05/14/15 to 07/13/15, with sing one time a week for 9 a set up. Review of the the skilled nurse failed to between during week one.  SOC 07/31/15, included a need by a physician for 07/31/15 to to 09/10/15, I nursing two to three times a to assess, medication nome health aide patient's overall health and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C 10/13/2015	
	PROVIDER OR SUPPLIER S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 170	home health aide ser day, three to five day personal care to incluor shower, shampoo, light housekeeping to safe environment. R notes, failed to evide 07/31/15 to 09/18/15  4. Clinical record #7 plan of care establish certification period of with orders for skilled monthly for medicatic Review of the skilled evidence skilled nurs 09/10/15.  5. Clinical record #9 plan of care establish certification period of orders for skilled nurs 09/10/15.  5. Clinical record #9 plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks. Review notes indicated that the extra visit during weef failed to follow the plan of care establish certification period of orders for skilled nurs nine weeks.	vices three to four hours a s a week to assist with ade partial to complete bath skin care, meal preparation, help maintain clean and eview of the skilled nursing nce skilled nursing visits.  SOC 08/05/15, included a need by a physician for 08/05/15 to to 09/30/15, I nursing one to four times on set up and assessment. nursing notes, failed to ing visits 08/05/15 to 11/26/15, with sing one time a week for of the skilled nurse made an ek one. The skilled nurse an of care.  Was unable to provide any in and / or information is referenced above by the 0/13/15 at 3:50 PM.	G 17				

PREFIX (EACH DEFICIENC	INC  TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	.	STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032  PROVIDER'S PLAN OF CORRECTION SHOULD FROM THE PROVIDER STATEMENT SHOULD FROM THE PROVIDER STATEMENT STATEMENT SHOULD SHOULD SHOULD FROM THE PROVIDER STATEMENT SHOULD SHOULD SHOULD SHOULD SHOU	C 10/13/2015
(X4) ID SUMMARY ST PREFIX (EACH DEFICIENC TAG REGULATORY OR	TATEMENT OF DEFICIENCIES  LY MUST BE PRECEDED BY FULL	ID PREFIX	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032 PROVIDER'S PLAN OF CORRECT	1 10/10/2010
PREFIX (EACH DEFICIENC TAG REGULATORY OR	Y MUST BE PRECEDED BY FULL	PREFIX		
G 173 Continued From page			CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE COMPLETION
NURSE  The registered nurse necessary revisions.	e 78 initiates the plan of care and	G 173	3	
Based on record rev Registered Nurse fail was updated to reflect periods, duties of dis the patient, changes current and discontin	not met as evidenced by: iew and interview, the led to ensure the plan of care ct the correct certification ciplines providing services to in wound treatments, and ued medications for 6 out of (#1, 2, 3, 5, 6, 7, 8, and 9)			
established by a physical of 08/03/15 with a cet to 10/03/15, with order time a week for wour ordered on the plan of	included a plan of care sician for a start of care date rtification period of 08/03/15 ers for skilled nursing one ad care. The treatment of care indicated for the ron-adherent dressing and similar product.			
10/08/15. Review of indicated the patient treatment on 07/20/1 be updated to reflect of 07/20/15 and a cert to 09/17/15. The pla include the location of clean the wound, and changes.	a. The clinical record was reviewed on 10/08/15. Review of the service agreement indicated the patient had signed consents for treatment on 07/20/15. The plan of care failed to be updated to reflect the correct start of care date of 07/20/15 and a certification period of 07/20/15 to 09/17/15. The plan of care also failed to include the location of the patient's wound, how to clean the wound, and frequency of dressing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	EINC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u> </u>	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
G 173	Plan of Care Synops ordered plan of care Diabetic foot care in presence of skin les and patient / caregiver care - yes, c. Falls d. Depression interreferral for other treatment that patient screene yes, e. Intervention - yes, f. Intervention yes, f. Interventions c. The medicatindicated "see attact plan of care failed to the medication profiprescribed.  2. Clinical record #2 plans of care establic certification period 0 09/05/15 to 10/31/19 nursing visits one to weeks and home he with personal care, reminder and light h safe and clean environments.  a. The Registe plan of care to reflect periods 07/29/15 to 11/25/15.  b. The Registe frequency and durate frequency and durat	sis Does the physician - e include the following b. cluding monitoring for the ions on the lower extremities wer education on proper foot prevention interventions - yes, wentions such as medication, atment, or a monitoring plan and / or physician notified d positive for depression - is to monitor and mitigate pain ins to prevent pressure ulcers - if care failed to be updated to is listed b - f.  ion portion of the plan of care hed medication profile." The include medications listed on le that the patient was taking /  2, SOC 07/29/15, included two shed by a physician for 17/29/15 to 09/05/15 and 5, with orders for skilled two times a week for nine ealth aide visits for assistance meal preparation, medication ouse keeping to maintain a	G 17				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	EINC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u> </u>	10/13/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 173	periods.  3. Clinical record #3 plan of care establis certification period of orders for a homem nine weeks for basic clean environment at hours per day up to weeks to socializatic writing, food preparareminders for medical Review of the ware Ages Home Health of Attendant Care Plate 03/06/15. Under the maker and compani Duties that were cheatide to provide inclupersonal hygiene (tushampoo, [miscellar shopping, errands, Inneeded" handwritter Registered Nurse facare to the include puriscellaneous job duthe "Aide / Homema".  4. Clinical record #4 plan of care establis certification period of 09/10/15 to 11/05/15.  The clinical record #4 plan of care establis certification period of 09/10/15 to 11/05/15.	provide for both certification  3, SOC 11/13/14, included a shed by a physician for of 05/14/15 to 07/13/15, with aker one hour per week for chousekeeping to maintain a and companion one to three five days a week for nine on assistance with letter ation, laundry, orientation, and ation.  Written plan of care titled "All Care, Inc. Aide / Homemaker an was initiated / dated on a attendant care title, home on was handwritten / added. Ecked off for the home health ded, but not limited to, ub bath, shower, sponge bath, neous jobs] included Or. appointments with "as an under the section. The illed to be update the plan of personal hygiene and uties that were indicated on other / Attendant Care Plan."  5, SOC 07/31/15, included a shed by a physician for of 07/31/15 to to 09/10/15 and 5.	G 17	73			
	at 12:00 PM. Revie indicated the patient						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C 10/13/2015	
	ROVIDER OR SUPPLIER  HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COL 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		0/13/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 173	3 Continued From page 81		G 1	73			
	-	the correct certification 09/28/15 and 09/29/15 to					
	plan of care establish certification periods of orders for home health hours per day five dates assist with "ADLs [act meal prep and light holder and safe environments of the profile indicated the posulfate 1 daily PO [by	SOC 08/04/15, included a ed by a physician with f 08/04/15 to 10/25/15, with the aide services one to four ys a week for eight week to tivities of daily living] and ousekeeping to maintain a mment." The medication eatient was taking "Ferrous mouth] and Q Pap 325 mg hours prn [as needed] for					
	10/13/15 at 12:30 PM be updated to reflect periods 08/04/15 to 1 the ADL duties that the provide to the patient failed to include the discussions.						
	dated 08/04/15, indic was to observe the paredications. The pla						
	assessment indicated diet. The plan of care on a regular diet. The	are comprehensive If the patient was on a no salt indicated the patient was e plan of care failed to be a patient was on a low salt					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	` '	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING _			C 10/13/2015		
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		18.18.2016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 173	updated plan of care 10/03/15 to 12/01/15 6. Clinical record #7 plan of care establis certification period o  The clinical record at 1:00 PM. The plat to reflect the correct 08/05/15 to 10/03/15 include an updated periods of 10/04/15 for 1	record failed to include an efor certification periods of 5.  7, SOC 08/05/15, included a hed by a physician for f 08/05/15 to to 09/30/15.  Ford was reviewed on 10/13/15 or of care failed to be updated certification period of 5. The clinical record failed to blan of care for certification	G 1	73				
	at 1:30 PM. The plato reflect the correct 09/08/15 to 11/06/15  8. Clinical record #9 plan of care establis certification period of a. The clinical record 10/13/15 at 1:43 PM be updated to reflect period of 09/30/15 to b. Review of the patient was takin ascorbic acid, aspirit flonase, gabapentin, oxycodone/acetamin	ecord was reviewed on The plan of care failed to the correct certification of 11/28/15.  The medication profile indicated a galbuterol sulfate, norvasc, in low dose, lipitor, nexium, cozar,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		15K131	B. WING	B. WING		10/	13/2015
	ROVIDER OR SUPPLIER  HOME HEALTH CARE	INC		1	STREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO			(X5) COMPLETION DATE
G 173	care indicated to see plan of care failed to medications that were profile.	the medication profile. The be updated to include the e listed on the medication	G	173			
	interviewed on 10/09/ of Nursing stated that certification period wa Administrator and Dir	as 30 days. The rector of Nursing had nothing rds to the start of care being					
G 174	indicated, " The ph		G	174			
	The registered nurse	furnishes those services and specialized nursing skill.					
	Based on Article 2 of Code, observation, re the Registered Nurse knowledgeable in pro	not met as evidenced by:  f the Indiana Administrative ecord review and interview, es failed to be prepared and eviding wound treatment and I home visits observed and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		15K131	B. WING	_		10/	13/2015
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALL AGES	HOME HEALTH CARE	INC			1081 THIRD AVENUE, SW, SUITE # 5		
				(	CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 174	patient patient's wour reviewed of patients of and 9)  Findings include:  1. Article 2. Standard Practice of Rule 2. Refulational Administrative Responsible to apply 1. The registered nurse Assess the patient / corganized manner provide for patient / corganized and skills competence in nursing professional growth. Responsibility as a mprofessional growth.	ds for the Competent egistered Nursing. 848 IAC re Code) 2 - 2 - 1 the nursing process. Sec. se shall do the following: (1) elient in a systematic, (4) Implement strategies to lient participation in health nee, and restoration. (5) is to assist the patient / client r health capabilities (7) ources and create learning nee and maintain current for his or her continuing g practice and individual 848 IAC 2 - 2 - 2 ember of the nursing he registered nurse shall do notion within the legal g practice based on the sand rules governing responsibility for individual continued competence. (3) orate, and function with he health team to provide safe by Seek education and sary when implementing niques 848 IAC 2 - 2 - 3 act Sec. 3. Nursing	G	174			
	behaviors (acts, know	vledge, and practices) failing standards of acceptable and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K131	B. WING				C <b>13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 174	public, shall constitute. These behaviors shato, the following: (1) technical skills, or inaproviding nursing carnursing technique or nurse is unprepared limit.  2. Clinical record #4, plan of care establish start of care date of Operiods 08/06/15 to 011/07/15 with orders wet to dry dressing clinips."  a. During a hom AM, with the Director observed to have a w trochanter, left buttoo trochanter and left but Director of Nursing proon the type of dressir had instructed the Director of Nursing proon the type of dressir had instructed the Director of Nursing proceeded to bedside table and as the measuring tool so wounds and proceed she would have to tal The patient right and wounds were a stage regards to length and Nursing was observe	s asfety, and welfare of the e unprofessional conduct. Il include, but are not limited Using unsafe judgment, appropriate behaviors in e. (2) Performing any procedure for which the by education or experience  SOC 08/04/15, included a need by a physician with a 18/06/15 and certification 9/25/15 and 09/26/15 to for skilled nursing daily for hanges to "decubes both he visit on 10/09/15 at 10:30 of Nursing, the patient was yound to the right and left left, an area between the left left left on the used. The patient rector of Nursing to use an roll and directed the Director of land directed the land on the ked the patient where was a that she may measure his left trochanter and left hip left rochanter and left hip left rochanter and left hip left on place a Q-tip on 4 x 4 leanser and sprayed over the	G	174			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING		10/13/20	115	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE I	L		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		15	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) IPLETION DATE	
G 174	Q-tip and then wiped 4 gauze. The Director to take the Q-tip and then placed the Q-tip and then placed the Q-tip tool on the 4 x 4 pack the package with the was observed to have areas in all three wou Nursing failed to mea tunneled areas.  The Director of Nask the patient if the Partie and told the Director of the routine Registered used Normal Saline to Director of Nursing pilabeled "Derma Gran informed surveyor the Saline. The Director kerlix gauze three times and proceeded to pack the kerlix, using the Coleaning. After packing Director of Nursing as padding came next be Director of Nursing the next, and proceeded gauze to place over the patient had to inston placement of the Poirector of Nursing procedure and fashio packing them firmly, a guidance from the patient had paid the patient had to inston placement of the Poirector of Nursing procedure and fashio packing them firmly, a guidance from the patient had to inston packing them firmly, a guidance from the patient had to inston packing them firmly, a guidance from the patient had to inston packing them firmly, a guidance from the patient had to inston packing them firmly, a guidance from the patient had to inston packing them firmly, a guidance from the patient had to inston packing them firmly, a guidance from the patient had to inston packing them firmly, a guidance from the patient had to inston packing them firmly.	to clean the wound with the the wound bed with the 4 x or of Nursing then proceeded hovered over the wound over top of the measuring age, then placed the Q-tip in kerlix dressing. The patient e undermining and tunneled nds and the Director of sure the undermining and	G 17	74			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		, ,	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C <b>0/13/2015</b>	
	NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP  1081 THIRD AVENUE, SW, SUITE #  CARMEL, IN 46032	CODE	0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 174	of Nursing of the releft trochanter and Nursing stated shand thanked the pout. Moving to the Nursing asked that Employee H of Nursing proceed Employee H wets patient the direction Throughout the drawing continued abilities to perform and if she had see would be more pronounced by the drawing failed to be the drawing asked the drawing asked the drawing failed to be removed prior to on Nursing failed to be removed prior to on Nursing failed to be removed the dressing for she the dressings for she drawing wound comprehensive as indicated the right 2 cm (centimeters and 4 x 4 cm. The measured.	page 87 patient had to inform the Director new wound located between the dibuttocks. The Director of e had not noticed the wound patient for pointing the wound e left heel, the Director of e patient what the treatment was does to the area. The Director ds to to ask the patient if the gauze and asked the form for which to place the gauze. The Director of the dressing change, the Director of the dressing change correctly en the patient more often, she officient. The Director of the patient more often, she officient. The Director of the patient what color was the ressings that he / she had but arrival. The Director of educate the patient not to fings or to save the dressings in registered nurse may observe signs of odor and infection.  The Director of the patient had but arrival to save the dressings in registered nurse may observe signs of odor and infection.  The Director of the patient that the patient of the cases ment on the start of care assessment on the start of care assessment dated 08/04/15, "hip" wound measured 7 x 5 x by, left hip wounds 5 x 4 x 2 cm are left heal failed to be utrising visit was made on	G	174			
		ursing visit was made on					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		15K131	B. WING _			C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032		10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 174	18 x 8 x 3 cm and or x 3 cm. The second failed to be measure document if the phys significant increase in d. A skilled nur 08/14/15, by Employ measured 18 x 10 x 3 x 4 x 2 and 5 x 4 x measured 2 x 2 x 0.3 to document if the physignificant increase in e. A skilled nurs 08/18/15, by Employ measured 18 x 15 x 3.5 x 3 x 1 cm and 5 measured 1 x 1 x 0.1 to document if the physignificant increase in f. A skilled nurs 08/24/15, by Employ measured 17 x 15 x 3 x 3 x 2.1 cm, 4 x 4 measured 1.5 x 1 x 2 failed to document if the significant increase wound.  g. The patient w 08/30/15 to 09/02/15 comprehensive asseperformed by the Dir documented wound in the significant increase measured 1.5 x 1 x 2 failed to document if the significant increase wound.	ed. The right hip measured be of the left hip wounds 5 x 6 hip wound and left heal down the nursing note failed to ician was notified of the nursing visit was made on ee H. The right hip wound was notified of the nursing visit was made on ee H. The right hip wound was notified of the nursing note failed by sician was notified of the nursing visit was made on ee H. The right hip wound was notified on the nursing visit was made on ee H. The right hip wound was notified of the nursing note failed was notified of the nursing note failed was notified of the nursing visit was made on end of the nursing note failed was notified of the nursing visit was made on	G 1	74		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		15K131	B. WING		C 10/13/2015
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRENCED TO THE APPRENC	JLD BE COMPLETION
G 174	dated 08/04/15.  h. An note in the 09/04/15, was entered entry indicated that Ereport that patients hand was resuming the heel as ordered."  i. Review of the dated 09/05/15 to 09 included / documented treatments.  j. A skilled nursi 09/07/15, by Employ measured 17 x 15 x 4 x 4.1 x 2 cm and 5 wound failed to be more sured 18 x 14 x 2 cm and 8 wound failed to be more failed to document if the significant incread wound.  l. The patient was to 09/25/15. The clir comprehensive asses hospital to include we description.  m. A skilled nursi 09/3/15, by Employe the patient had a "deep the significant incread wound.	e patient's chart dated ed by the Administrator. The Employee H had "called to eel decube had reopened e wet to dry dressings to left skilled nursing visit notes /14/15, the left heel was not ed in the daily wound wound ng visit was made on ee H. The right hip 2 cm, the left hips measured x 4.5 x 3.9 cm. The left heal easured.	G 17	74	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			1	STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	1 10/	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 174	tissue. Skilled nursin 10/02/15, failed to incomplete developing a pressure skin on 10/03/15.  n. A skilled nursin 10/04/15, by Employe measured 12 x 10 x 3 10 x 10 x 2 cm and 7 between the left "hips cm. The left heel me o. A skilled nursin 10/09/15, by the Direct hip measured 6 x 4 x measured 6 x 5 x 3 cwound between the left The Director of Nursin her measures, label the correctly, as per previous performed by Employ Skilled nursing visit no 10/08/15, Employee I were light pink with we partial granulation. Edocument specific de that provides location white tissue and sloud appearance of surrouwound.  3. Clinical record #9, plan of care establish certification period of	ppearance of surrounding g visits from 09/26/15 to licate that the patient was e ulcer prior to eruption of sing visit was made on the H. The right hip B cm, the left hips measured x 4 x 2 cm. The new area with measured 2.5 x 2.5 x 2 asured 1 x 1 x 0.1 cm.  In wisit was made on the control of Nursing. The right 3 cm, the left hips measured 3 x 2 wheel measured 2 x 2 cm. The woleft "hips" measured 3 x 2 wheel measured 2 x 2 cm. The left hips and heel wound with the left hips and heel wound with the left hips and heel wound with the wounds white - yellow slough tissue or mployee H failed to be scriptions for each wound and percentage of pink to	G	174			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED
		15K131	B. WING		C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
G 174	for healing and poss evaluate ulcer on rig progression to healir increase size.  a. Review of the comprehensive asses M1330 under the Intitute patient had a state unobservable and M had an observable signality. The confailed to include locate the surgical incision of the stasis ulcer and unobservable.  b. Review of the 10/02/15, indicated the wound to the right to assessment of the state indicated in the complete that she had represent the state of the sta	ate left below the knee stump lible skin breakdown and ht "bk" [below the knee] for any or non healing and  e OASIS start of care assement dated 09/30/15, segumentary Status, indicated sis ulcer that was 1340 indicated the patient aurgical wound that was fully amprehensive assessment and failed to include location and failed to include location and reason for the ulcer to be skilled nursing notes dated the patient had an open se but failed to include an aurgical wound that was orehensive assessment.  Ursing was interviewed on M. The Director of Nursing not worked as a nurse since of she had been an infusion is.	G 17	4	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		15K131	B. WING			10/	13/2015
	ROVIDER OR SUPPLIER  HOME HEALTH CARE I	NC		10	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 174	reviewed on 10/13/15 of Nursing indicated in care, that it had been she had provided woo record failed to includ wound care care by the form of Nursing was hired.  7. An undated policy Services", indicated "Provides services required skill "  8. An undated policy indicated, "Provides of management for a teat accordance with the saccordance of the plans of care with the saccordance with the saccordance to the plans of care with the saccordance with the saccordanc	rsing personnel record was at 3:00 PM. The Director in her proficiency of wound more than 12 months since and care. The personnel is a skills check off for the agency after the Director in titled "Skilled Nursing The registered nurse uiring specialized nursing it titled "Registered Nurse" direct care and case am of Agency clients in state Nurse Practice Act and of the AIDE SERVICES in the thick as evidenced by: we wand interview, the home insure written plans of care oddted for the appropriate		202			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
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		15K131	B. WING		<del></del>	10/	13/2015
	ROVIDER OR SUPPLIER  HOME HEALTH CARE I	INC			s, CITY, STATE, ZIP CODE NUE, SW, SUITE # 5 6032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 202	Continued From page companion services (		G	202			
G 224	resulted in the agency with the Condition of Health Aide.	t of this systemic problem y being out of compliance Participation 484.36 Home	G	224			
	health aide must be p nurse or other appropresponsible for the su	enstructions for the home orepared by the registered oriate professional who is upervision of the home ragraph (d) of this section.					
	Based on record revi agency failed to ensu designed and update discipline, included di written plans of care v	ietary restrictions, and were written for specific 3 records reviewed with					
	Findings include:						
	the physician for the one of the one of the one of the one of the patient incontinence of bowe hair care, transfer to one of the one	plan of care established by certification period of for home health aide in the morning 7 days a t, skin care secondary to el and bladder, dress, diaper, wheelchair, prepare urs in the evening 7 days a					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K131	B. WING		C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
G 224	diaper, partial to cor transfer to bed. The written plan of care evening home healt specified within the  2. Clinical record #3 plan of care establis certification period corders for a homemnine weeks for basic clean environment a hours per day up to weeks to socialization writing, food preparareminders for medical a. Review of the health aide was disconsidered by the companion of the companion	rel and bladder, clean dry implete bath as needed, e agency failed to provide a for the morning and for the h aide services that was established plan of care.  3, SOC 11/13/14, include a shed by a physician for of 05/14/15 to 07/13/15, with aker one hour per week for c housekeeping to maintain a and companion one to three five days a week for nine on assistance with letter ation, laundry, orientation, and action.  see physician orders, the home continued on 12/01/14.  see written plan of care titled "All Care, Inc. Aide / Homemaker an was initiated / dated on e attendant care title, home on was handwritten. Duties giene (tub bath, shower, coo. "Standing assist" was this section. Housekeeping um, clean bathroom, clean thes, wash linens, and wash "was written under "wash included breakfast, lunch,	G 22	4	

STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		15K131	B. WING _			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		10/13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 224	companion may per practice and as order of care.  3. Clinical record #4 a plan of care estable certification periods orders for home head day, seven days a wand maintain a safe  a. During a hor AM, the patient state himself / herself and daily from 5:00 - 9:0 apartment appeared unkept. At the conducted where he / shim / herself around  b. Review of the plan of care dated 0 health aide was to pas tub bath, shower hygiene, and shave included clean bath as meal prep. The verial plan of care dated of the plan o	ge 95 form within their scope of pered by the established plan  I, SOC 0807//06/15, included lished by a physician with of 09/26/15 to 11/07/15, with allth aide services four hours a peek for bathing, skin care and clean environment.  The visit on 10/09/15 at 10:30 and that he / she bathes the home health aide comes to PM for housekeeping. The late to be disorganized and lusion of the visit, the patient of the was observed wheeling the apartment parking lot.  The late the home health aide written 8/06/15, indicated the home rovide personal hygiene such hair care, skin care, oral Housekeeping duties soom and wash dishes as well written plan of care failed to the late of the stable written plan of care failed to the late of the stable witten the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable witten plan of care failed to the late of the stable plan of the stable pla	G 2	· ·			
	4. Clinical record #6 plan of care establis certification periods orders for home hea hours per day five d assist with "ADLs [a meal prep and light	S, SOC 08/04/15, included a hed by a physician with of 08/04/15 to 10/25/15, with alth aide services one to four ays a week for eight week to ctivities of daily living] and housekeeping to maintain a conment." The start of care					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	L	1	S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u>  107</u>	13/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 224	was on a no salt diet. written plan of care di include the patient was 4. The Administrator additional information the exit conference of 5. An undated policy Services" indicated, "assesses the need fo includes the services [orders]. A specific ca documenting the Aide "	ssment indicated the patient The home health aide ated 08/04/15, failed to as on a low salt diet.  was unable to provide and / or documentation by n 10/13/15 at 3:50 PM  titled "Home Health Aide The nurse or therapist r personal care services and in the physician plan of care are plan is developed e services to be provided	G	224			
G 225	Assignment" indicated tasks will be identified care plan / Assignment 484.36(c)(2) ASSIGN HOME HEALTH AIDED The home health aided ordered by the physical that the aide is permittlaw.  This STANDARD is represented the aided to experience the services provided in a services with a services provided in a services with aided to experience the services and the services will be also as a service to the aided to experience the services will be also as a service to the services will be a service to the serv	MENT & DUTIES OF e provides services that are cian in the plan of care and tted to perform under state  not met as evidenced by: ew and interview, the home insure visits were made and accordance to the plan of lis reviewed with home	G	225			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C <b>0/13/2015</b>	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 225	physician for certifica 10/03/15, with orders services three hours week to bathe patien incontinence of bowe hair care, transfer to breakfast and two ho week to provide skin incontinece of bowel diaper, partial to com to bed. Patient diagr vascular accident [str depression, lymphad diabetes.  a. Review of the notes indicated there visits between 07/20/were missed on 08/0 08/16, 08/17, 08/19, 09/08, 09/09, 09/10, 1	s, SOC (start of care) clan of care established by a claim of care secondary to claim of bladder, dress, diaper, wheelchair, prepare curs in the evening 7 days a care secondary to and bladder, clean dry clete bath as needed, transfer closes included cerebral coke] with hemiplegia, ema, stasis ulcers, and ce Home Health aide visit ce were no home health aide ce Home Health aide ce Home Health aide visit ce were no home health aide ce Home Health ai	G 22	25			
	08/22 (only 1 hour pr 08/27, 08/31, 09/01, 09/09, 09/10, and 09 combined in one visit PM), 08/08 ( 9:00 AM AM - 2:30 PM), 08/19 (9:00 AM - 1:15 PM). failed to follow the pla	home health aide services bloyee *, a registered nurse,					

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	PLE CONSTRUCTION  3	, ,	TE SURVEY MPLETED
		15K131	B. WING		1	C <b>0/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		0/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 225	and did garbage rerindicate if the bathroemployee did not fo 2. 08/04, t kitchen, laundry, chabed, washed dishes dusted. The employee did not 3. 08/05, t changed bed / made The employee did not so cleaned. The employee did not so cleaned and garbage removindicate if a meal was bathroom was cleaned follow the plan of ca 6. 08/08, t kitchen, laundry, chabed, washed dishes employee did not in and if the bathroom did not follow the plan of ca 7. 08/09, t dusted and mopped indicate if a meal washeen provided with the employee did not fo 8. 08/10, t washed dishes, and employee did not in or if hair care had be	ne employee did the laundry moval. The employee did not som was cleaned. The slow the plan of care. The employee cleaned the anged the bed / made the garbage removal and wee did not indicate if a meal the bathroom was cleaned. The employee did the laundry, the bed, and garbage removal. The employee did not follow the memployee did not follow the sprepared and if the ted. The employee did not re. The employee cleaned the laundry and the bed / made the laundry and garbage removal. The dicate if a meal was prepared was cleaned. The employee	G 22	25		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K131	B. WING_			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP COD 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
G 225	changed bed / made vaccuumed, and morindicate if a meal was bathroom was cleaned follow the plan of car 10. 08/19, changed bed / made The employee did not prepared and if the bathroom was cleaned. 12. 08/21, changed bed / made vaccuumed, and morindicate if a meal was bathroom was cleaned follow the plan of car 13. 08/22, change bed / made to the employee did not prepared and if the bathroom was cleaned on the control of the bathroom was cleaned of the plan of car follow the plan of car follo	the employee did the laundry, bed, garbage removal, oped. The employee did not is prepared and if the ed. The employee did the laundry, bed, and garbage removal. In the employee did laundry, bed, and garbage removal. In the employee did laundry, age removal, vaccuuming, ployee did not indicate if a and if the bathroom was the employee did the laundry, bed, garbage removal, oped. The employee did not is prepared and if the ed. The employee did not et. The employee did the laundry, bed, and garbage removal. In the employee did the laundry, bed, and garbage removal. In the employee did the laundry, bed, and garbage removal. The ow the plan of care. The employee did the laundry, garbage removal. The icate if a meal was prepared was cleaned. The employee nof care. The employee did laundry, bed, garbage removal, and mopped. The employee neal was prepared and if the ed. The employee did not	G 2	225			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	· /	ATE SURVEY DMPLETED	
		15K131	B. WING			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	: INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		10/13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 225	change bed / made The employee did no prepared and if the lemployee did not for 17. 08/26, kitchen, did laundry, garbage removal, va employee did not ind and if the bathroom did not follow the pla 18. 08/27, change bed / made The employee did not for 19. 08/28, changed bed / made garbage removal. if a meal was prepart cleaned. The employer care. 20. 08/29, changed bed / made yaccummed, and du indicate if a meal was bathroom was clean follow the plan of ca 21. 08/30, changed bed / made mopped. The employer care. 22. 08/31, garbage removal, ar employee did not ind provided, a meal was bathroom was clean follow the plan of ca 23. 09/01,	bed, and garbage removal. of indicate if a meal was cathroom was cleaned. The low the plan of care. the employee cleaned the change bed / made bed, accuumed, and mopped. The dicate if a meal was prepared was cleaned. The employee an of care. the employee did laundry, bed, vaccuumed, and dusted. of indicate if a meal was cathroom was cleaned. The low the plan of care. the employee did laundry, bed, washed dishes, and The employee did not indicate red and if the bathroom was oyee did not follow the plan of the employee did laundry, bed, garbage removal, asted. The employee did not reserve did not follow the led. The employee did laundry, bed, garbage removal, asted. The employee did not reserve did not follow the plan of the employee did laundry, bed, garbage removal, and oyee did not follow the plan of the employee did laundry, bed, garbage removal, and oyee did not follow the plan of the employee did laudry, of vaccuumed. The dicate if hair care was s prepared, and if the led. The employee did not of the employee did not of the employee did laudry, of vaccuumed. The dicate if hair care was s prepared, and if the led. The employee did not	G 25	25			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		15K131	B. WING			C <b>10/13/2015</b>
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 225	and if the bathroom of did not follow the plan 24. 09/02, made bed and garbated did not indicate hair of was prepared, and if The employee did not 25. 09/04, changed bed / made mopped. The employee was provided, a mean bathroom was cleaned follow the plan of car 23. 09/05, changed bed / made vaccuumed, and dust follow the plan of car 24. 09/06, change bed / made was mopped. The employeem and the mopped. The employeem and the mopped was grown and the mopped was grown and the employeem and the e	icate if a meal was prepared, was cleaned. The employee in of care. The employee changed bed / ge removal. The employee care was provided, a meal the bathroom was cleaned. It follow the plan of care. The employee did laundry, bed, garbage removal, and yee did not indicate hair care I was prepared, and if the ed. The employee did not et. The employee did the laundry, bed, garbage removal, and yee did not follow the plan of the employee did the laundry, bed, garbage removal, and yee did not follow the plan of the employee did n	G 22	25		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING		-		C <b>13/2015</b>
	ROVIDER OR SUPPLIER	L		1	STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u>  10/</u>	13/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 225	aide visit note, the aiderrands for the patient failed to follow the plate of the patient of the patient failed to follow the plate of the patient of care establish start of care date of the periods 08/06/15 to 011/07/15 with orders of the services daily for bath a safe and clean enviorable of the plan of care date of the plan o	and 09/14/15 home health de indicated that she had ran t. The home health aid an of care.  SOC 08/04/15, included a ed by a physician with a 8/06/15 and certification 9/25/15 and 09/26/15 to for home health aide hing, skin care, and maintain ronment.  e visit on 10/09/15 at 10:30 de that he / she bathes the home health aide comes PM for housekeeping. The to be disorganized and asion of the visit, the patient and proceeded to go e was observed wheeling the apartment parking lot.  home health aide written 1/06/15, indicated the home by order personal hygiene such mair care, skin care, oral	G	225			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG	· ,	ATE SURVEY DMPLETED	
		15K131	B. WING _			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP CO 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	DDE	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 225	The home health aid care / written plan of 4. Clinical record #5 plan of care establis certification period o with orders for home four hours a day, thr assist with personal complete bath or she meal preparation, lig maintain clean and s  a. The clinical r 10/13/15 at 12:00 Pl 09/03/15, indicated 'visits three to five he days per week. Rev visit notes on 10/13/there were no home 07/31/15 to 09/06/15  b. A physician of indicated to "decrease one hour per day, se approval. Increase secondary to family serior of the care of the car	mopped, and ran errands.  le failed to follow the plan of care.  is, SOC 07/31/15, included a hed by a physician for f 07/31/15 to to 09/10/15, health aide services three to ee to five days a week to care to include partial to ower, shampoo, skin care, th housekeeping to help cafe environment.  eccord was reviewed on M. A physician order dated PHHA [home health aide] ours per day, three to five riew of the home health aide 15 at 12:00 PM, indicated health aide visits between 5.  order dated 09/17/15, se home health aide visits to econdary to Medicaid visits to seven days per week weekend coverage not	G 2	225			
	aid visits notes, indicated seeing the on 09/13/15. The horosolution follow the plan of cares. Clinical record #8 plan of care establis certification period of orders for home hear	"Review of the home health cated that the home health e patient for one hour per day ome health aide failed to re.  S, SOC 09/08/15, included a hed by a physician for f 09/08/15 to to 11/03/15, with aide one to two hours a ys a week up to ten hours per					

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING		C 10/13/2015		
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIC		
G 225	complete bath, showlight housekeeping to environment.  a. The clinical re 10/13/15 at 1:30 PM. notes dated 09/09, 00 indicate if a meal had housekeeping had be declined both service failed to follow the plate b. Review of the dated 09/14, 09/15, 009/22, 09/23, 09/24, 10/01, 10/02, 10/06, 10/10/15, failed to in prepared or if the pat service. The home high plan of care.  6. On 10/13/15 at 10 stated that she had saide for patient #4, at bathe himself prior to care, and the home high patient when needed 7. An undated policy Services" indicated, "health aide include the personal care The and will not initiate ne services without contile / therapist "	ersonnal care / ADLs ng) and to include partial / er, skin care, meal prep and o help keep a safe and clean  ecord was reviewed on The home health aide visit 19/10, and 09/11/15, failed to 1 been prepared and if light een done or if the patient had es. The home health aide an of care.  e home health aide visit notes 19/16, 09/17, 09/18, 09/21, 10/9/25, 09/28, 09/29, 09/30, 10/07, 10/08, 10/09, and dicate if a meal had been	G 22				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		15K131	B. WING				C <b>13/2015</b>
	ROVIDER OR SUPPLIER	L		108	REET ADDRESS, CITY, STATE, ZIP CODE 81 THIRD AVENUE, SW, SUITE # 5 ARMEL, IN 46032	1 10/	13/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 225	will document care / s home health aide cha provided should be in provided in the Home	ated, "Home Health Aides services provided on the irting form. Care / Services accordance with direction Health Aide Care Plan "		225			
G 227			G 2	227			
	Based on record revi agency to ensure ser within the homemake	not met as evidenced by: ew and interview, the vices were to be provided r / companion scope of ords reviewed of patients r and / or companion					
	plan of care establish certification period of orders for a homemal nine weeks for basic clean environment an hours per day up to fi weeks to socialization	05/14/15 to 07/13/15, with ker one hour per week for housekeeping to maintain and companion one to three we days a week for nine assistance with letter ion, laundry, orientation, and					
	Ages Home Health C / Attendant Care Plan 03/06/15. Under the	itten plan of care titled "All are, Inc. Aide / Homemaker was initiated / dated on attendant care title, home n was handwritten / added.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 501251			С	
		15K131	B. WING			10/ <sup>-</sup>	13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE I	NC		STREET ADDRESS, CITY, STATE, ZIP COD 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
G 227	attendant to provide in personal hygiene (tub shampoo. The written updated to exclude poindicated on the "Aide Care Plan."  2. The Administrator additional information the exit conference on	cked off for the homemaker / ncluded, but not limited to, bath, shower, sponge bath, n plan of care failed to be ersonal hygiene that was e / Homemaker / Attendant  was unable to provide and / or documentation by n 10/13/15 at 3:50 PM.		235			
	Based on record revi agency failed to ensu authentic and transcri 1 of 9 records reviewed The cumulative effect	not met as evidenced by: ew and interview, the re that a clinical record was ibed by the visiting nurse for ed.  of this systemic problem y being out of compliance					
G 236	with the Condition of Records. 484.48 CLINICAL RE A clinical record contacurrent findings in accurrent findings in accurrent receiving hom addition to the plan of appropriate identifying physician; drug, dieta	Participation 484.48 Clinical  CORDS  aining pertinent past and cordance with accepted is is maintained for every	G	236			
	addition to the plan of appropriate identifying physician; drug, dieta orders; signed and da notes; copies of sumr	f care, the record contains g information; name of ry, treatment, and activity					

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K131	B. WING		C 10/13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ILD BE COMPLETION
G 236	Continued From page	e 107	G 23	6	
	Based on record revagency failed to ensuauthentic and transcr 1 of 9 records review  1. Clinical record #1, 07/20/15, included a	, SOC (start of care) plan of care established by			
	a. A comprehen dated 08/03/15, was Nursing. Most of the comprehensive asse Director of Nursing. assessment in the coprognosis, a different observed and indicat non-compliant and m	sive nursing assessment performed by the Director of OASIS start of care ssment was filled out by the			
	by Employee G. The admit the patient to h	er dated 08/03/15, was written everbal order indicated to some care.  are line #23 indicated the btained a verbal for start of			
	d. A skilled nurs made by Employee 0 waiting for a return pl e. An entry note	sing visit dated 08/05/15 was 3 who indicated she was hone call by the physician.  e dated 08/06/15 at 1:00 PM ated the physician would			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '			(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C 10/13/2015	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE I		<u>. I</u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	1 10/	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 236	requested the plan of office.  2. The Administrator	nome care services and care to be faxed to his	G	236			
	assistance with her w tell her what to write a Administrator's entrie following the Administ Administrator also sta	g had an injury and needed riting, so the Director would and review and initial the s. There was no initials trator's entry. The sted that she was a former d no longer holds a license.					
G 250	10/09/15 at 11:45 AM stated she had an inju would tell the Adminis		G	250			
	the program, review a	enting at least the scope of a sample of both active and s to determine whether re followed in furnishing					
	Based on record revi agency failed to ensu professionals, represe the program, reviewe quarterly to determine	not met as evidenced by: ew and interview, the re that appropriate health enting at least the scope of d active and closed records e established policies were urnished for 1 of 1 agency.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		15K131	B. WING		1	C D/13/2015	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 250	Finding include:  1. The agency had a 20, 21, 22, and May put a plan of corrections inclusive a. Weekly monivisits and verification documentation of mistic patient's physician b. Staff in-service nutritional requireme  c. The profession in-serviced on the reaphysician's order for ordered and any chaphysicians order.  d. The Director for reviewing patient orders on a weekly be physician's order for each patient to prevede ficiency.  e. The Director for monitoring patien other professional stapatient needs and inschanges in regard to plan.  f. The profession the requirement of determine the content of the requirement of determine the content of the requirement of the content of th	a provision survey dated April 4, 2015. The agency had to on in place by May 20, 2015. ded, but not limited to:  toring of patient's plan of care of these visits or seed visits and notification of n.  ces on the need to document ints on the plan of care.  onal staff was to be quirement to document with or the specific wound care inges in wound care per  of Nursing will be responsible care plans and physician's asis and securing care changes as needed on ent recurrence of this  of Nursing was responsible to care and conferencing with aff to determine specific stituting the appropriate the home health aide care  nal staff was in-services on etailed documentation and its to medication profile. The	G 25	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X2) MULTIPLE (X3) MULTIPLE (X4) MULTIPLE (X			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	
		15K131	B. WING			10/	13/2015
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALL AGES	HOME HEALTH CARE	INC			081 THIRD AVENUE, SW, SUITE # 5		
				- C	CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 250	Continued From page		G	250			
	• .	admissions, resumption of and 60 day certifications to this deficiency.					
	The agency failed to omaintain, and evaluat performance improve	e a quality assessment and					
	10/09/15 at 11:45 AM field often and does n time in the office. The indicated she started June 1, 2015 and that	the Director of Nursing on I, stated that she is in the lot spend a large amount of e Director of Nursing working for the company on the former Director of In to be a per diem nurse in					
		stated that the Director of missions, recertifications,					
G 330	Nursing is responsible was not able to produ The administrator also had a QAPI meeting the Provisional Licens	stated that the Director of e for the chart audits but lice any audited material. o stated the agency has not to review audit findings since	G:	330			
	provide, a patient-spe assessment that accu current health status	urately reflects the patient's and includes information demonstrate the patient's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K131	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	<u> </u>	10/13/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 330	must identify the pathome care and mee nursing, rehabilitativ planning needs. For HHA must verify the Medicare home hea homebound status, assessment visit and comprehensive assessment must all current version of the Information Set (OA language and group specified by the Sector This CONDITION is Based on record referensure that the common completed in its entitle start of care for 334); failed to ensurincluded a start date potential side effects of the patient / caregoreconciliation with the care and failed to do patient / caregiver up 9 records reviewed (that comprehensive was updated within day episode for 5 of patients who had se (See G 339); failed the assessments were concerned a patient's return from records reviewed of 340); and failed to e	prehensive assessment ient's continuing need for the patient's medical, e, social, and discharge Medicare beneficiaries, the patient's eligibility for the the benefit including both at the time of the initial dat the time of the essment. The comprehensive so incorporate the use of the e Outcome and Assessment SIS) items, using the ings of the OASIS items, as	G 33	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DESCRIPTION NUMBER:  A. BUILDING				(X3) DATE COMP	SURVEY LETED
		15K131	B. WING			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	INC	ı	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032	107	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 330	Continued From page of 3 patients reviewed services (See G 341)	d that was discharged from	G	330			
G 334		ssments of Patients. ETION OF THE	G	334			
		manner, consistent with the eeds, but no later than 5					
	Based on record revi ensure that the comp completed in its entiri	not met as evidenced by: iew, the agency failed to rehensive assessment was ty and within five days of the record reviewed. (#1)					
	the physician for the	plan of care established by					
	assessment dated 08 location and size of voto complete vital signs assessments, complete assessment of bowel	of care comprehensive 1/03/15 failed to include 1/03/15 failed to include 1/03/15 failed 1/03/15					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				-		(	c
		15K131	B. WING			10/	13/2015
	ROVIDER OR SUPPLIER  6 HOME HEALTH CARE I	NC		1	ORTREET ADDRESS, CITY, STATE, ZIP CODE  O81 THIRD AVENUE, SW, SUITE # 5		
				(	CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 334	screening score of 6 vindicate if the patient nursing services, failed any management of e24 hr supervision / cle transfers / infection cosafety measures, and instructions / material of the assessment fail provided during the action of Nursing failed to coassessment in its entitle admission.  2. The Administrator interviewed on 10/09/PM. The Administrator Nursing does all of the cares, and recertificat does the skills check	o address the depression with the physician, failed to was receiving psychiatric ed to indicate if there was equipment, failed to include ear pathways / lock w/c with portrol measures under	G	334			
G 337	had nothing further to of care being the sam signed.  3. An undated policy Process" indicated, " professional will Co Form, including OASI 484.55(c) DRUG RECOMMENT The comprehensive a review of all medication using in order to identificated and drug reacting therapy, significations	add in regards to the start te day consents were  titled "The Admission The admission omplete the Assessment S data elements "	G	337			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K131	B. WING			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	NC	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 337	Based on record reviagency failed to ensurincluded a start date opotential side effects, of the patient / caregireconciliation with the care and failed to do patient / caregiver up 9 records reviewed.  Findings include:  1. Clinical record #4, plan of care establish start of care date of 0 periods 08/06/15 to 0 11/07/15. The correct 08/04/15 to 10/02/15. profile indicated the minclude a start date of potential side effects, of the patient / caregireconciliation with the care and failed to do patient / caregiver up  2. Clinical record #5, plan of care establish certification periods 0 09/10/15 to 11/05/15. periods 07/31/15 to 0 11/27/15. Review of indicated the register start date of medicatic effects, date of drug reconciliation of drug response to the patient of drug response to the patient of date of medicatic effects, date of drug respective to the patient of drug respective to the patient of the patient	anot met as evidenced by: we and interview, the re that the Medication profile of the medication ordered, date of drug regimen review ver, and medication e physician at the start of a drug regimen review of the on recertification for 6 out of (#4, 5, 6, 7, 8, and 9)  SOC 08/04/15, included a ed by a physician with a 8/06/15 and certification 9/25/15 and 09/26/15 to t certification period was Review of the medication egistered nurse failed to f medication ordered, date of drug regimen review ver, and medication e physician at the start of a drug regimen review of the on recertification.  SOC 07/31/15, included a ed by a physician with 7/31/15 to 09/10/15 and The correct certification 9/28/15 and 09/29/15 to	G	337			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING		C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER	E INC		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
G 337	drug regimen review upon recertification.  3. Clinical record # plan of care establis certification periods correct certification and 10/03/15 to 12/medication profile ir failed to include a d failed to include rou Q Pap medications, side effects, a date the patient / caregiver reconciliation with the care and failed to depatient / caregiver upon 4. Clinical record # plan of care establis certification periods correct certification and 10/04/15 to 12/medication profile ir failed to include the medications, a date	of the patient / caregiver  6, SOC 08/04/15, included a shed by a physician with of 08/04/15 to 10/02/15. The periods 08/04/15 to 10/02/15 01/15. Review of the indicated the registered nurse osage for the Ferrous Sulfate, te to the Ferrous Sulfate and failed to include potential for the drug regimen review of the include potential for the drug regimen review of the include potential for the drug regimen review of the include potential for the drug regimen review of the include potential for the drug regimen review of the included a shed by a physician with of 08/05/15 to 09/30/15. The periods 08/05/15 to 10/03/15 02/15. Review of the indicated the registered nurse start date and route for all of or the drug regimen review	G 33	,		
	reconciliation with the care and failed to depatient / caregiver upon 5. Clinical record # plan of care establis certification period of Review of the medial registered nurse fail said medications - control of the medial registered nurse fail said medications - control of the medial registered nurse fail said medications - control of the medial registered nurse fail said medications - control of the medial registered nurse fail said medications - control of the medial registered nurse fail said medial registered nurse fail registere	giver, and medication ne physician at the start of o a drug regimen review of the upon recertification.  8, SOC 09/08/15, included a shed by a physician for of 09/08/15 to to 11/03/15. cation profile indicated the led to include the purpose of oxycontin, amlodipine, aspirin, e, atorvastatin, and carvedilol				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						l .	
		15K131	B. WING			10/	13/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALL AGES	S HOME HEALTH CARE I	NC.		1	081 THIRD AVENUE, SW, SUITE # 5		
ALLAGE	O HOME HEALTH CARE			С	CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 337	a date for the drug recaregiver, and medical physician at the start.  6. Clinical record #9, plan of care establish certification period of  a. Review of the the registered nurse for date, potential side effects. h. Discontine period of the medication reconciliants in the exit conference of the start of administrator additional information the exit conference of th	ide effects, failed to include gimen review of the patient / ation reconciliation with the of care.  SOC 09/30/15, included a ed by a physician for 09/30/15 to to 11/26/15.  medication profile indicated failed to include the start fects, complete the drug patient / caregiver, and tion with the physician, and in profile with date at the start forder dated 10/05/15, was ordered to have The medication profile failed and the neosporin ointment.  was unable to provide and / or documentation by in 10/13/15 at 3:50 PM  of titled "Medication Profile" al Instructions 1. At the time hission professional shall a client may be taking to ective drug therapy or gnificant side effects 3. e shall document b. Date	G	337			

l ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			l	C 13/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032			13/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 337	sixty [60] days and up change or discontinual Registered Nurse shat Medication Profile up minimum, every sixty 484.55(d)(1) UPDATE COMPREHENSIVE AT The comprehensive a updated and revised of the OASIS) the last beginning with the statis a beneficiary electer change in condition reconstruction.	a Registered Nurse very odated whenever there is a ation in medication. The all sign and date the on initiation and, at [60] days thereafter " E OF THE ASSESSMENT  assessment must be (including the administration to 5 days of every 60 days art of care date, unless there are d transfer; or significant esulting in a new case mix arge and return to the same	G :	337			
	Based on record reviensure that comprehe assessments was upeduring the 60 day epireviewed with patient than 60 days. (#2, 4, Findings include:  1. Clinical record #2, plans of care establis certification period 07 09/05/15 to 10/31/15. nursing visit notes includes.	dated within the last 5 days sode for 5 of 5 records s who had services longer					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	С
		15K131	B. WING			10/	13/2015
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE I	NC		1	TREET ADDRESS, CITY, STATE, ZIP CODE  081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 339	the last 5 days during  2. Clinical record #4, plan of care establish start of care date of 0 periods 08/06/15 to 0 11/07/15. The correc 08/04/15 to 10/02/15. nursing visit notes, th complete the recertific the last 5 days during  3. Clinical record #5, plan of care establish certification period of 09/10/15 to 11/05/15. period of 07/31/15 to 11/27/15. Review of notes, the registered recertification assess during the 60 day epical 4. Clinical record #6, plan of care establish certification periods o correct certification periods o correct certification periods of correct certification assess during the 60 day epical 5. Clinical record #7, plan of care establish certification period of The correct certification period of The correct certification for the correct certification	ered nurse failed to cation assessment within the 60 day episode.  SOC 08/04/15, included a ed by a physician with a 8/06/15 and certification 9/25/15 and 09/26/15 to t certification period was Review of the skilled e registered nurse failed to cation assessment within the 60 day episode.  SOC 07/31/15, included a ed by a physician for 07/31/15 to to 09/10/15 and The correct certification 09/28/15 and 09/29/15 to the skilled nursing visit nurse failed to complete the ment within the last 5 days sode.  SOC 08/04/15, included a ed by a physician with f 08/04/15 to 10/25/15. The eriod of 08/05/15 to the skilled nursing visit nurse failed to complete the ment within the last 5 days sode.  SOC 08/04/15, included a ed by a physician with f 08/04/15 to 10/25/15. The eriod of 08/05/15 to the skilled nursing visit nurse failed to complete the ment within the last 5 days sode.	G	339			

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		15K131	B. WING _			C <b>10/13/2015</b>	
	ROVIDER OR SUPPLIER  S HOME HEALTH CARE	INC		STREET ADDRESS, CITY, STATE, ZIP C 1081 THIRD AVENUE, SW, SUITE # CARMEL, IN 46032		10.10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 340	during the 60 day epi  6. The Director of No. 10/09/15 at 1:30 PM. stated that she had the period was 30 days.  7. An undated policy / Update of Compreheindicated, " Reasseleast: 1. Every secons beginning with start of days of the episode, Each professional disfor reassessing care - six [56 -60] days whoservices " 484.55(d)(2) UPDATE COMPREHENSIVE ATTOMOREHENSIVE ATTOMOREHENSIVE ATTOMOREHENSIVE ATTOMOREMENT OF THE COMPREHENSIVE ATTOMOR	ment within the last 5 days sode.  ursing was interviewed on The Director of Nursing hought the certification  titled "Client Reassessment ensive Assessment " essments must be done at nd calendar month of care {within last five [5] including day sixty [60] scipline will be responsible // services at least every fifty file the client is skilled  E OF THE ASSESSMENT	G				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K131	B. WING			C <b>10/13/2015</b>	
NAME OF PE	ROVIDER OR SUPPLIER	ionio:		_	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	13/2015
					1081 THIRD AVENUE, SW, SUITE # 5		
ALL AGES	HOME HEALTH CARE	INC		CARMEL, IN 46032			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE	
G 340	Continued From page 120		G	340			
		plan of care established by a physician with a					
	· ·	8/06/15 and certification					
	periods and 09/26/15	to 11/07/15. Review of the					
		rder to hold services due to					
		pitalized from 09/18/15 to					
		Il record failed to include a omprehensive assessment					
		charge from the hospital.					
		onalge nem are neophan					
	2. The Director of Nu	ırsing was interviewed on					
		The Director of Nursing					
		es out in the field and does					
	not use the OASIS fo	or of Nursing stated once					
	she gets back to the	<del>-</del>					
	_	nputer and prints it out once					
		ctor of Nursing indicated that					
	she did not print this r						
		she was having problems					
		stem saving her information. ng was not able to provide					
	any further informatio						
	arry fartifier informatio	11.					
	3. An undated policy	titled "Client Reassessment					
	/ Update of Comprehe	ensive Assessment"					
		essments must be done at					
		y - eight [48] hours of [or					
		eturn home from hospital an twenty - four [24] hours of					
		n diagnostic testing "					
G 341	484.55(d)(3) UPDATE	_	G	341			
	COMPREHENSIVE A						
	The comprehensive a						
	•	(including the administration					
	of the OASIS) at disc	narge.					
	This STANDARD is r	not met as evidenced by:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K131	B. WING		C 10/13/2015		
NAME OF PROVIDER OR SUPPLIER  ALL AGES HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE  1081 THIRD AVENUE, SW, SUITE # 5  CARMEL, IN 46032	10/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
G 341	agency failed to ensassessment was coof 3 patients reviews services. (# 1 and 3 Findings include:  1. The clinical record o7/20/15, was revier record included a ple physician for a start a certification period orders for skilled nu wound care.  a. The last skill 08/19/15.  b. The last hor on 09/06/15.  c. The letter dathe agency was discondischarge assessment.  2. The clinical record in established by a phyof 05/14/15 to 07/13.  a. Review of the last skilled nursing b. Review of the discharge the patients.	view and interview, the sure that a comprehensive impleted upon discharge for 2 and that was discharged from 3)  Indicate that was done on 3)  Indicated that was done	G 34				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		451/424	B. WING				C
	20//255 05 0//25//55	15K131	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	10/	13/2015
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
ALL AGES	HOME HEALTH CARE I	INC	1081 THIRD AVENUE, SW, SUITE # 5				
					CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 341	Continued From page assessment.	e 122	G	34 <i>^</i>	1		
	the chart was closed of Employee G did not do summary on patient #  4. An undated policy / Update of Comprehe indicated, " Reasse	I. The Administrator stated on 07/11/15 and that do a discharge visit or 43.  titled "Client Reassessment ensive Assessment" essments must be done at y - eight [48] hours of [or					